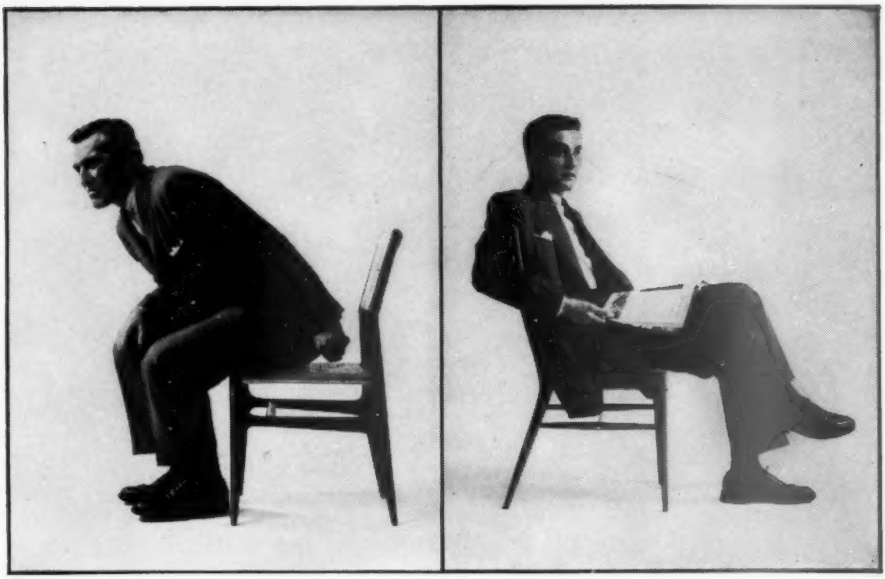
R.N.

a journal for nurses

A
SURGICAL
SYMPOSIUM

May 1955

Of two patients with pruritus ani . . .



one is at his wit's end—his lesion excoriated by constant scratching, peace of mind gone, and sleep, too.

The other is symptomatically controlled.

Calmitol makes the difference

Nonsensitizing and free of the dangers of "rebound dermatosis," Calmitol is "preferred"[1] by physicians for its safe and prolonged antipruritic action.

1½ oz. tubes and 1 lb. jars

1. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.

For free sample write to:

Thos. Leeming & Co. Inc. **155 East 44th Street, New York 17, N. Y.**

R.N.

contents

MAY, 1955
VOL. 18, NO. 5

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departments

COVER CREDITS: R.N.'s *cover features Mrs. Jean Campbell, R.N., the supervisor of nurses for the operating rooms, Department of Surgery, The Ohio State University Health Center, Columbus, Ohio. Mrs. Campbell is removing her mask following a surgical procedure. The photograph was taken by Robert H. Albertin, assistant director, Medical Illustration, The Ohio State University Health Center.*

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MANUSCRIPTS *are always welcomed by the editors—particularly those written on nursing and allied subjects by interested authors. Manuscripts should be typed, with double or triple spacing. Send photographs and/or illustrations with manuscript whenever possible. All published manuscripts become the property of* R.N. *Manuscripts not accepted will be returned to their authors.*

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STERILWRAPS

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Safe, Re-usable, Economical Wrappers
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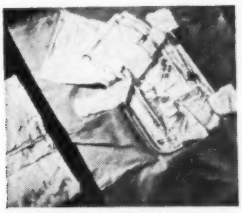
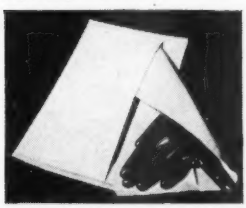


STERILWRAPS are suitable for wrapping a wide range of soft goods and instruments, such as Lumbar Puncture Sets (above), Intravenous Sets, Drainage Sets, etc.



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IF YOU ARE studying for your Bachelor's or Master's Degree in Nursing, you now have an opportunity to complete up to a year of your education with officer pay and allowances of over $4,000. A limited number of Army commissions are now available to registered nurses who are currently accepted or enrolled in an approved college course.

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To qualify for the Registered Nurse Student Program of the Army Nurse Corps, you must be single, a registered nurse, between 21 and 32 years of age and of high moral character. In addition, you must be accepted or enrolled as a full time student in an approved collegiate nursing program...with the ability to complete your course within one year.

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THE SURGEON GENERAL
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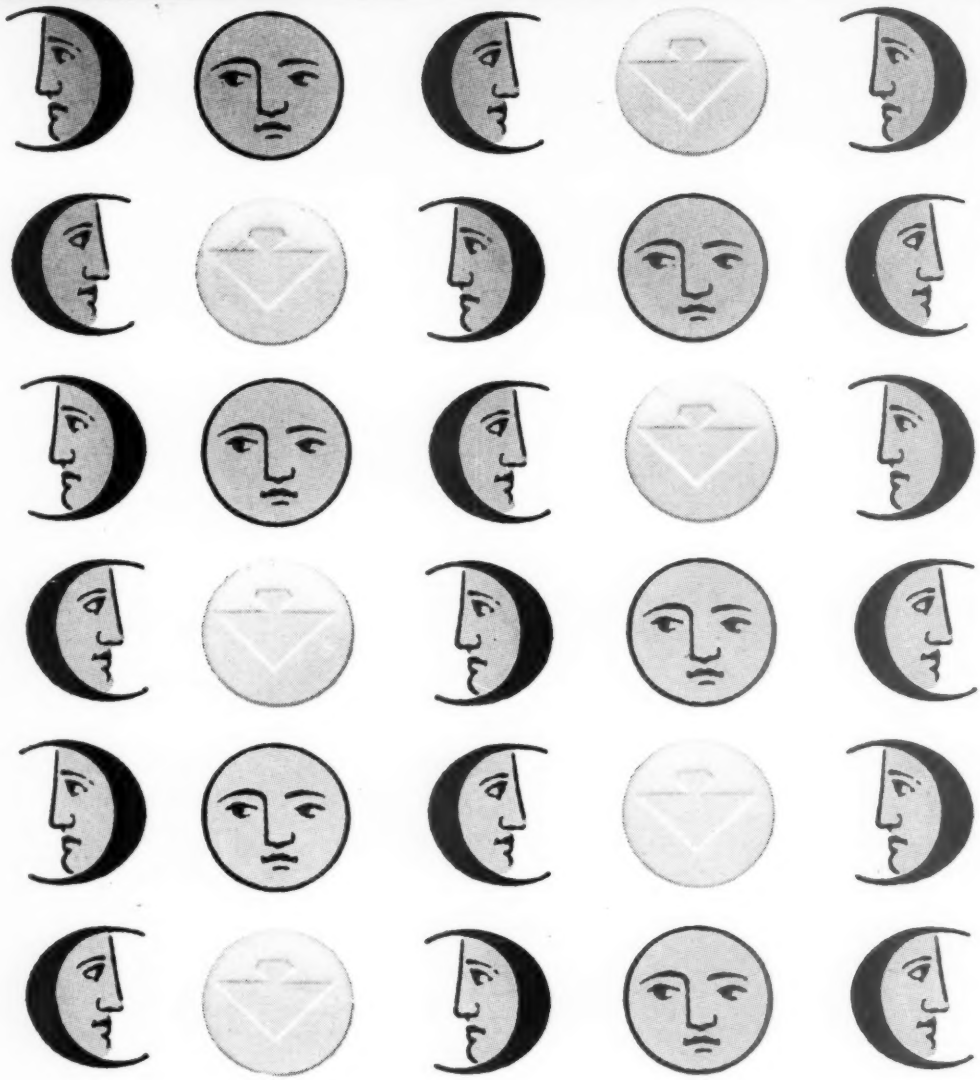
Attn: Chief, Personnel Division

DON'T WAIT!—*Only a limited number of Army commissions are offered under the student program. Apply today!*

U. S. ARMY
Nurse Corps



repeated tests prove faster pain relief with Anacin

Tests, recently completed on a significant number of patients, again prove Anacin to be a faster acting analgesic than either aspirin or a buffered type aspirin. Patients who received Anacin revealed the presence of the main metabolite of phenacetin in the bloodstream minutes before any salicylates could be detected. Results were confirmed in subsequent tests. The type of quick, dependable relief that Anacin provides is available to your patients who may obtain Anacin at the nearest pharmacy.

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Debits and Credits

A Postscript

Dear Editor:

I would like to thank the many nurses who wrote to me, personally, praising my letter in the November, 1954 **R.N.**, as well as my courage to write it regardless of criticism.

It would be too great a task to write a note to each. My thanks also to the hospital administrator who assured me that I was not alone in my opinions, and to Mr. Ingersoll and Miss Janet Geister for their tact and courtesy in voicing their views.

I felt that we owed it to the young nurses being recruited, to offer them a better ANA (not a union), one "of the nurse, by the nurse, and for the nurse."

A membership of 30 per cent does not prove it to be very strongly "of the nurse," nor is the majority's opinion that it is "for the nurse."

HELEN E. JAMES, R.N.
EAST ELY, NEV.

At 18¢ an Hour

Dear Editor:

It pays me to stay home! The letter from Myra L. Wiedman in *D & C*. February, 1955 strikes at the core of "why married professional nurses remain inactive."

I can't work in a hospital eight hours a day, care for three children, husband, and home unless I hire a housekeeper. Here's how the figures add up in Mississippi:

Daily Private Duty Wage:	$10.00
Expenses to work:	
Housekeeper	$5.00
Meal at hospital	.75
Laundry	.60
Tax deductions	2.20
Total expenses and deductions	8.55
Take-home pay	$ 1.45

The take-home pay averages 18¢ an hour. Even the new legislation for working mothers doesn't help, for my husband is mentally balanced and physically fit.

EDWINA RUBENSTEIN, R.N.
BILOXI, MISS.

Disgruntled

Dear Editor:

I enjoy **R.N.** very much, even though our district officers belittle all who read it. For all of our high dues in California, the Association does very little for us in return.

I have never attended a meeting yet, when we aren't asked to donate money. At that rate we can't afford to go to meetings.

Recently, we have had a series of TB cases ordered off isolation technique as soon as special nurses came on the cases. This not only endangered the nurse, but also kept her

from collecting $2.00 more each shift for communicable disease care.

Reports to the district get nowhere. When I suggested it be mentioned to the state officers, I was told our officers feel there will be "no such thing as private duty" in two years. Is it any wonder nurses gripe?

(MRS.) HELEN BEAUCHAMP, R.N.
SAN DIEGO, CALIF.

Active Again

Dear Editor:

In my opinion, **R.N.** is the most outstanding of our professional nursing magazines.

I have recently returned to hospital staff nursing after an absence of several years. I find **R.N.** invaluable in helping me readjust. It's a cinch I can't change the hospital, so I must change.

But what pangs in giving up the close bedside nursing of former years! I am a supervisor of a large ward, and it is impossible for four nurses and four aides, over a sixteen-hour period, to give good care to the twenty-five or thirty patients in this ward.

Bless Janet Geister for all her helpful articles.

(MRS.) PHYLLIS B. CASPER, R.N.
ROCKY MOUNT, N.C.

A Philosophical Approach

Dear Editor:

I think **R.N.** is one of the best in its field, and I particularly enjoy Janet Geister's *Candid Comments.* We do need to examine the ground

Keep cool...look fresh

in this bright, white, modern style with nylon mesh vamp

The Aircool

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It's the new look on the job—the smart, crisp, becoming look of modern styling for "women in white." Notice the airy nylon mesh . . . that keeps you feeling so cool and fresh. Look at the non-skid rubber sole and heel . . . that walk so softly. Choose The Aircool . . . for the finest warm weather duty shoe you ever wore and wore.

WRITE TODAY for the name of your nearest retailer. We'll also send a beautiful plastic shoe horn with our compliments. The United States Shoe Corporation, Cincinnati 7, Ohio.

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AMERICA'S SMARTEST SELECTION OF MODERN STYLES

This product has no connection whatever with The American National Red Cross

our professional house is built on, and her sane, lucid approach will, I am sure, prove most fruitful.

You cannot intelligently decide how anything should be treated until you are quite clear about what it is. *What* man is, will determine *how* he is to be treated. Techniques and their application must be designed to serve him in view of what he is.

We meet him when he is mechanically impaired, economically strained, mentally depressed, and perhaps spiritually distraught. If we treat him simply as an ulcer or a gall bladder, or any defective part, without reference to his total composition of soul, body, and mind, we will have demeaned both him and ourselves.

Work takes on dignity in proportion to the worth of its object. The answer to the question—what man is and what are his needs—will shape our profession in the coming years.

IRENE M. DURFOS, R.N.
GARY, IND.

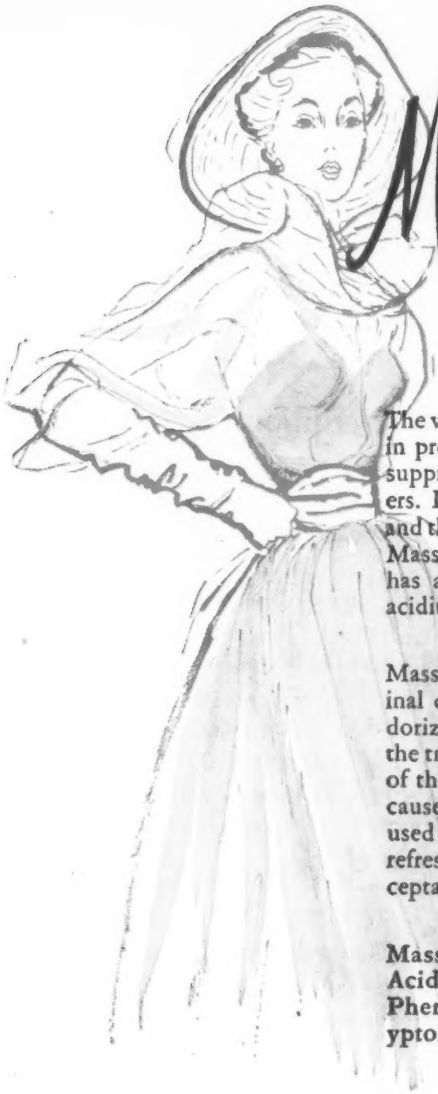
T.L. for "R.N."

Dear Editor:

I have been receiving your wonderful magazine since 1940, and I thoroughly enjoy every issue.

I did hospital and industrial nursing until June, 1954 when I grew weary of the long hours of supervisory nursing in a small town. I decided I needed a change and a little left-over energy for my two children.

After taking some postgraduate courses last summer, I became a



Massengill POWDER

acid vaginal douche

The vaginal acid reaction is an important factor in preserving the normal vaginal flora and in suppressing the growth of undesirable invaders. It is rational, therefore, to use cleansing and therapeutic applications with an acid pH. Massengill Powder in the standard solution has a pH of 3.5 to 4.5, approximating the acidity of the normal, healthy vagina.

Massengill Powder solution provides a vaginal douche that is cleansing, soothing, deodorizing, and highly useful as an adjunct in the treatment of many pathological conditions of the vaginal tract producing leukorrhea. Because the solution is nonirritating, it can be used for routine feminine hygiene. Its clean, refreshing odor makes Massengill Powder acceptable to the most fastidious patient.

Massengill Powder contains: Boric Acid, Ammonium Alum, Berberine Salt, Phenol, Menthol Isomers, Thymol, Eucalyptol and Aromatics.

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GENEROUS SAMPLE
ON REQUEST

county public health nurse. The work is both challenging and stimulating, and I feel it will be beneficial to my children, myself, and I hope, to the community.

I have always wanted to express my appreciation to the magazine which I received free for so many years. Today, in my opinion, **R.N.** far surpasses magazines that cost four times as much.

(Mrs.) Naomi D. Ide, R.N.
ORANGE CITY, IOWA

Prescription

Dear Editor:

I am a New Jersey graduate and had never worked with practicals until I moved to Washington.

I think the R.N.'s gripe is that practicals, once in a while, try to tell us how to do our work.

I believe they should attend courses in Professional Adjustments.

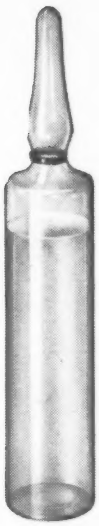
Bertie Daye Pross, R.N.
YAKIMA, WASH.

Good Idea

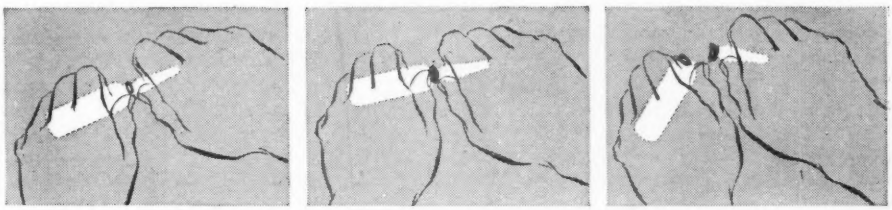
Dear Editor:

The article on a two-year nursing course in the January issue of **R.N.** was very interesting and practical. If a third year, or internship, in special fields was offered following this two-year course, I think it would help eliminate the nursing shortage in certain fields.

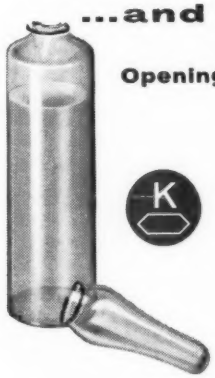
At Westfield State Sanatarium, we give a fifteen month's course in nursing. At the end of this course, trainees take the state board exam-



"GRIP!" "BEND!" "SNAP!"



...and your ampul is ready to use



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NO FILING. NO SAWING. NO SCORING.

A solution sealed in a Kimble Color-Break Ampul can't be tampered with; you can be sure it will always be kept as pure and sterile as the day it was packaged.

Many producers of parenteral solutions are already using Kimble Color-Break Ampuls. You can recognize them by the distinctive blue band around the neck of the ampul.

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inations for licensed practical nurses. We feel they receive good training in both medical and surgical nursing, obstetrics, and pediatrics.

We appreciate the help they give us and the very fine work they do here where we treat only tuberculosis and cancer patients.

MARY C. LOWE, R.N.
WESTFIELD, MASS.

Too Drastic

Dear Editor:

The article "An R.N. in Two Years" is typical of many plans offered to alleviate the nursing shortage. At the end of World War I, the shortage was solved by bestowing R.N. degrees on one and all who so much as lifted a thermometer. A few years ago we had the Brown and Ginsburg Reports, and now we are offered the two-year plan. All of these solutions have one common factor—they jeopardize the R.N.'s status, and, consequently, the patient's safety.

There are a great many R.N.'s who would be able to work if hospitals would take the time to consider their problems and work out a plan with them. There are many girls who would enter training if more scholarships were available.

As far as two years being more attractive than three, I think if anyone has the true spirit of nursing, they will be willing to spend three years to learn it properly.

Then, too, by shortening the training period, it draws the line pretty

Fewer recurrences in PSORIASIS

I=76% E=38% R=19%
with RIASOL

The most discouraging feature of psoriasis is recurrence. Ormsby and Montgomery* write: "The disease often recurs, and may do so repeatedly for the greater part of a lifetime."

Clinical investigation shows that in psoriasis treated with RIASOL recurrence is exceptional. In a series of resistant psoriatics, classified as therapeutic failures to other drugs, there was improvement with RIASOL in 76% of cases, eradication of the lesions in 38%, and recurrence in only 19%. Such recurrences responded readily to further treatment with RIASOL.

The explanation for these unusual results is to be found in the deep action of RIASOL in the prickle-cell layer of the stratum mucosum, from which the cutaneous lesions of psoriasis originate.

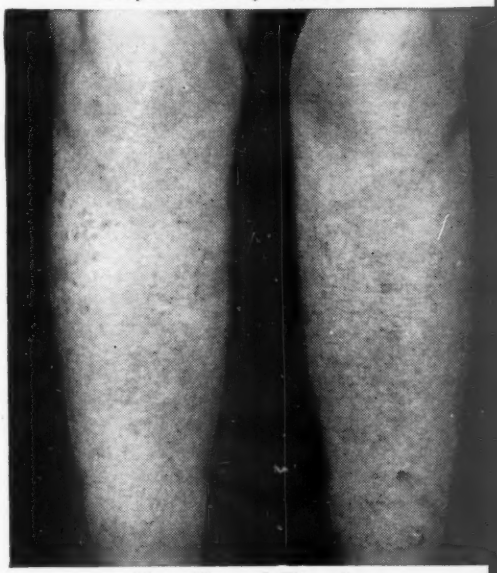
RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

***Ormsby, O.S. & Montgomery, H., *Diseases of the Skin*, 6th ed., 1943, p. 291.**

Before Use of Riasol



After Use of Riasol

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SHIELD LABORATORIES
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Please print name and address plainly. Not sent without Reg. No. R.N. 5-55

Please send me professional literature and generous clinical package of **RIASOL.**

.....R.N. **Reg. No.**.....

Street .....

City ..... Zone ..... State .....

RIASOL FOR PSORIASIS

thin between an R.N. and a practical nurse.

All in all, this is too drastic a step to take until a few more obvious solutions have been tried.

MARGARET BLUM, R.N.
ROCHESTER, N.Y.

OK-*If Workable*

Dear Editor:

Hurray for the nursing profession! I am so happy to find a possible solution to the great shortage of professional nurses. Your article in the February issue, "An R.N. in Two Years," gave some serious thought to the possible solution of this shortage.

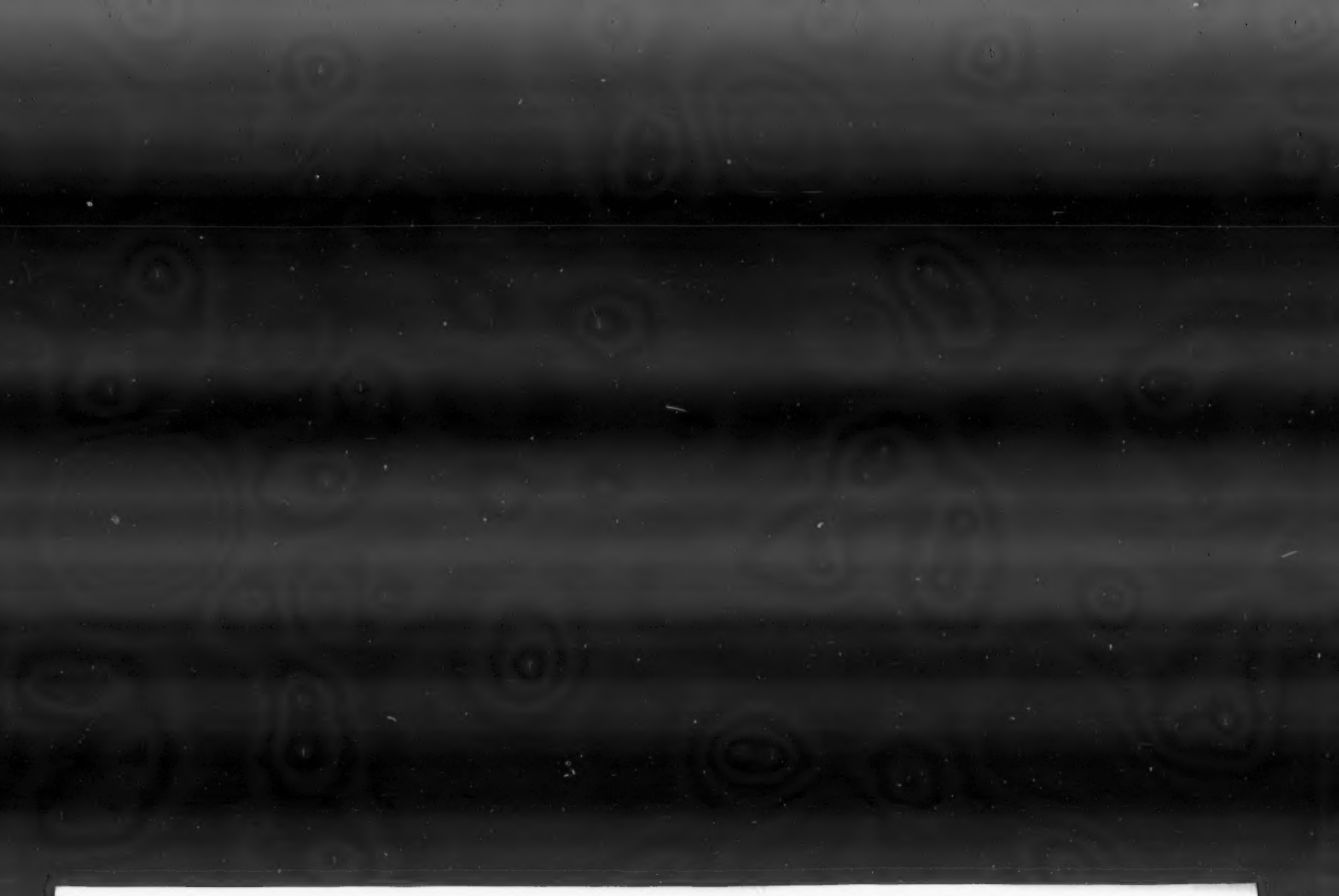
If a two-year course for nurses can be made workable, I'm all for it. The need for good bedside nurses is just as great as that for degree nurses in the proper functioning of a hospital.

Higher education has always been available to all who cared to work for it, and I'm sure anyone with high ideals will always obtain all the education they are mentally able to grasp and can afford. However, some are content to do their desired work—that of being prepared to give good professional bedside care. It's very rewarding to see a patient restored to health as the result of this care.

I don't want to see the standards lowered, but if this program is workable, let's get it rolling and help relieve this terrible shortage.

Your magazine is tops. I haven't missed one issue since it began.

(MRS.) JANET HALM
PERU, ILL.



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for the bland diet

1 OVALTINE PROVIDES A WEALTH OF ESSENTIAL NUTRIENTS

And in a balanced relationship of protein, vitamins, minerals and other nutrients. See chart below.

2 OVALTINE IS HIGHLY PALATABLE

The tempting flavor of this delicious food beverage adds zest to the bland diet. It is taken eagerly even by patients who dislike milk.

3 OVALTINE REDUCES CURD TENSION OF MILK MORE THAN 60%

This dietary supplement is an easily digested addition to the bland diet.

Thus, Ovaltine, made with milk is ideally suitable whenever a bland diet is required.

Ovaltine is equally delicious served hot or cold.

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS

*CALCIUM	1.12 Gm.	MAGNESIUM	120 mg
CHLORINE	900 mg.	MANGANESE	0.4 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.
COPPER	0.7 mg.	POTASSIUM	1300 mg.
FLUORINE	0.5 mg.	SODIUM	560 mg.
IODINE	0.7 mg.	ZINC	2.6 mg.
*IRON	12 mg.		

VITAMINS

*ASCORBIC ACID	37.0 mg.	PYRIDOXINE	0.6 mg.
BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
CHOLINE	200 mg.	*THIAMINE	1.2 mg.
FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
PANTOTHENIC ACID	3.0 mg.	*VITAMIN D	420 I.U.

*PROTEIN (biologically complete)	32 Gm.
CARBOHYDRATE	65 Gm.
FAT	30 Gm.

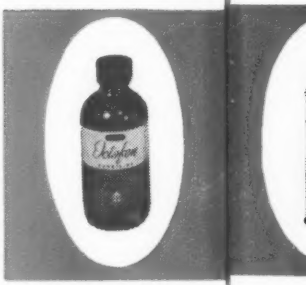
*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Ovaltine

The Wander Company
360 N. Michigan Ave., Chicago 1, Ill.

The World's Most Popular Fortified Food Beverage

Whatever it's all



FAST ACTION WITH OCTOFEN LIQUID

Athlete's foot calls for *fast action* to prevent undue spreading and serious complications. That's why OCTOFEN LIQUID is becoming an increasing professional favorite in the treatment of this multi-named scourge. OCTOFEN LIQUID, containing the fungicide 8-hydroxyquinoline in effective concentrations, kills T. mentagrophytes (arch criminal in athlete's foot) *fast*—in 2-minutes by laboratory tests. Nipped in the bud with OCTOFEN LIQUID, early athlete's foot never gets a foothold; advanced cases often respond to treatment in as little as two weeks time. Clinical studies[1] reveal that OCTOFEN LIQUID is effective in more than 90% of all cases tried. Popular with your patients, OCTOFEN is kind to the tender infected skin, greaseless, non-staining, quick drying. No awkward wet dressings or packs required – just swab the affected parts generously at the office – treatment continued at home until relieved.

1. Exp. Med. & Surg. 7:37, 1949.

its name

the same to OCTOFEN®

You can get real scientific and diagnose it as trichophytosis or T. megalosporon. Or you may prefer the terms epidermophytosis, dermatophytosis, or one of several other fungal tongue-twisters. But whatever you call it – whatever its name, it adds up to just plain understandable *athlete's foot* with the telltale symptoms – itching, reddened, painful, broken-down skin, between the toes and on the feet; in unchecked cases, possible involvement of the hands, groins, thighs and other parts.

OCTOFEN POWDER – *COMPANION PRODUCT*

Containing moisture-absorbent silica-gel as well as the active fungicide, OCTOFEN POWDER serves as sound supplementary therapy. Silk smooth and soothing, OCTOFEN POWDER, dusted liberally on the feet, in socks and shoes, helps keep the feet dry (a *must* in treatment), curbs foot odors, too. By itself, OCTOFEN POWDER is an effective prophylactic measure.

McKESSON & ROBBINS
INCORPORATED
Bridgeport 9, Conn.

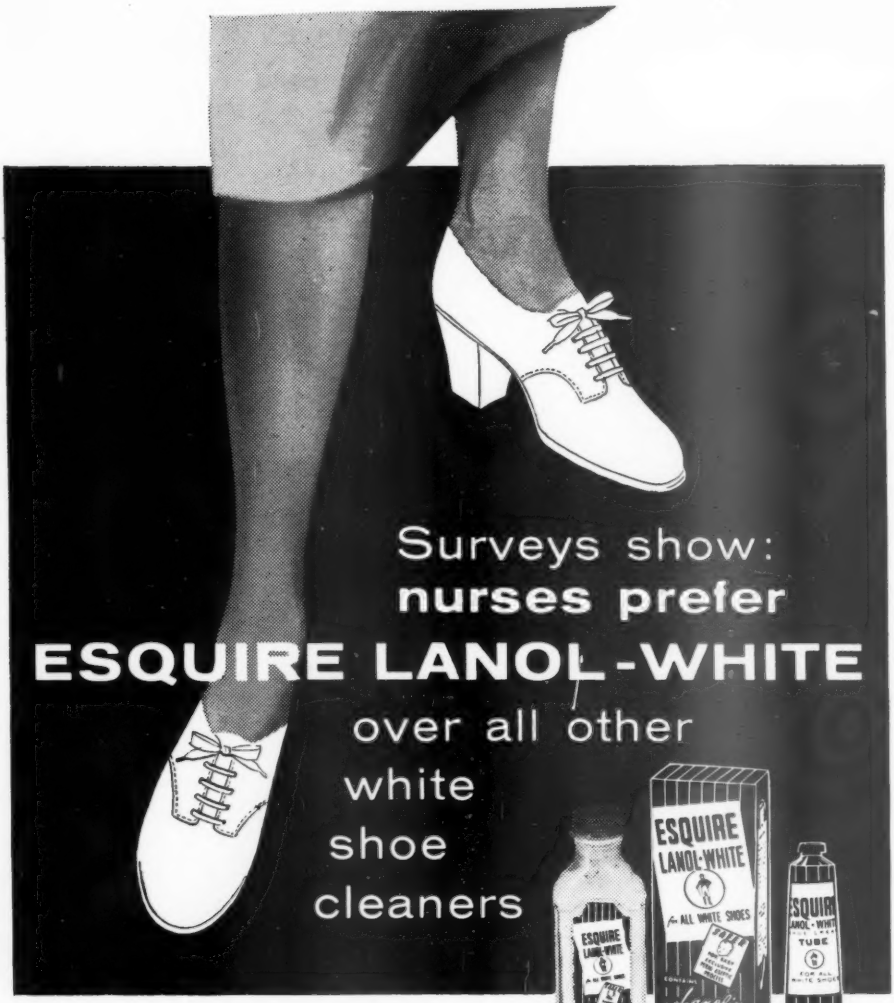
McKesson & Robbins, Inc., Dept. R.N.
Bridgeport 9, Conn.

Kindly send me free samples of your OCTOFEN LIQUID and OCTOFEN POWDER.

Name_____ R.N.

Address_____

City_____ Zone____ State_____



in bottles or in tubes

Recent surveys by an important nursing magazine* proved Lanol-White is the white shoe cleaner preferred and used by more nurses than the next 3 brands *combined!* For good reasons: Lanol-White goes on fastest, smoothest, easiest. It removes dirt completely . . . dries fastest, with a stubborn stay-on quality that keeps shoes whitest-white longer. Lanol-White, the only white shoe cleaner with Lanolin, keeps shoes kitten-soft, too; ***keeps them from drying out and cracking.*** Try Esquire Lanol-White next time. You'll make it your *Number One Choice,* too!

*Name on request

there is nothing quite like

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to keep baby's skin clear, smooth, supple, free from rash, excoriation and chafing

Desitin Ointment has proven its soothing, protective, healing qualities[1-4] in over 30 years of use on millions of infants in . . .

DIAPER RASH · DERMATITIS · INTERTRIGO · IRRITATION

FOR *samples* AND LITERATURE PLEASE WRITE...

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

DESITIN CHEMICAL COMPANY
70 Ship Street • Providence 2, R. I.

1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
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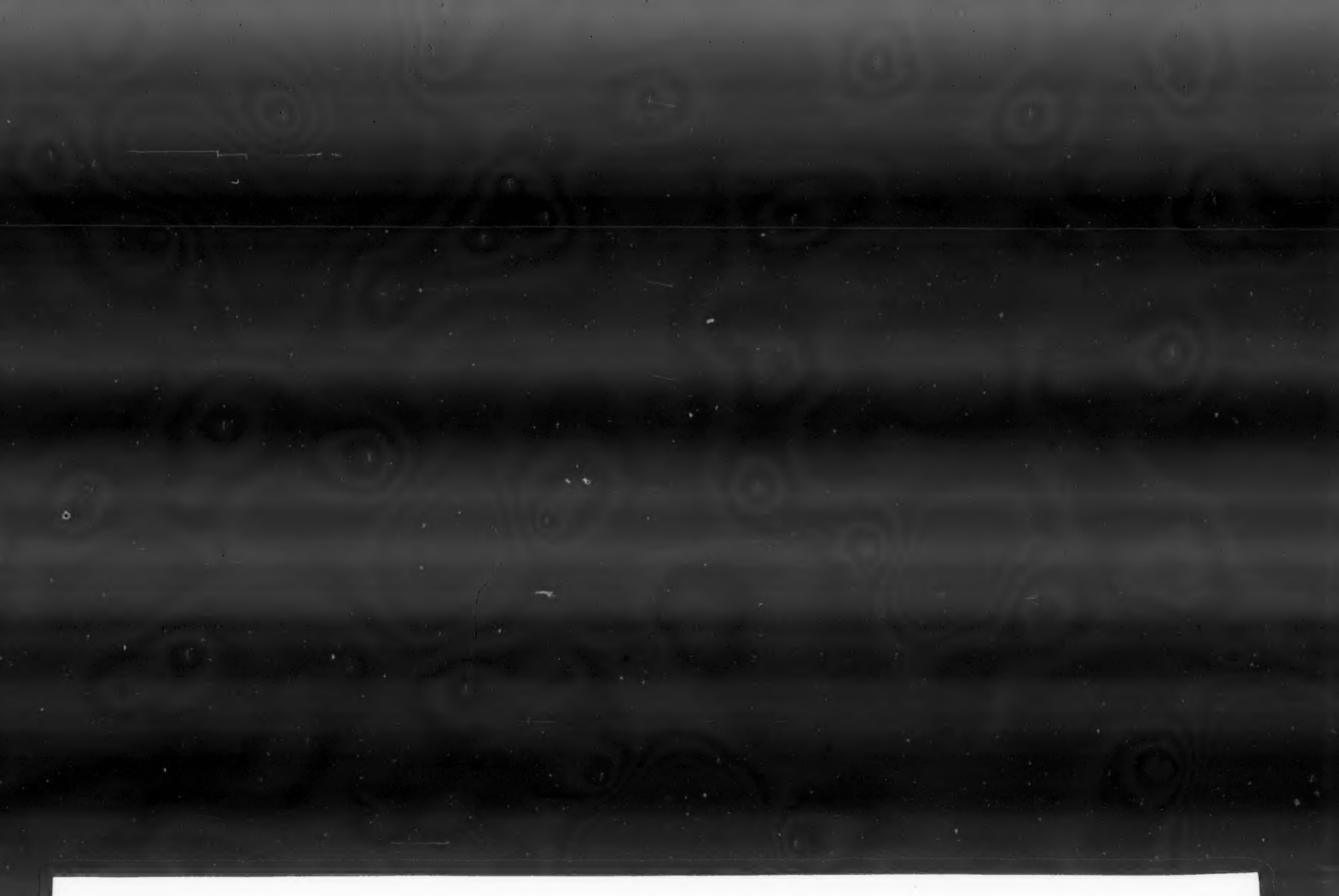

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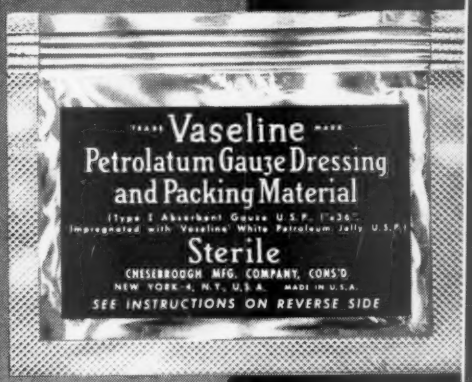

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A Prologue to the Surgical Symposium

■ UNDER USUAL circumstances, a report of a sectional meeting of the American College of Surgeons would be relegated to the news section of this magazine; it would not be the basis for an entire issue. Then what took place at the February Section Meeting of the American College of Surgeons, held in Cleveland, Ohio, that should so influence the **R.N.** editors to depart so radically from their customary editorial policy of a balanced issue?

An extremely important "first" accounts for our decision.

In an unprecedented move, the American College of Surgeons launched an educational program for all who were concerned with the treatment of the surgical patient—"from the pre-operative workup, through preparation for surgery, anesthetic, operation, recovery room, hospitalization period, and rehabilitation phases of the after care."

It was the College's proposed aim to create a team spirit among those surgeons, anesthesiologists, anesthetists, and nurses who participate in the overall care of the surgical patient—in the operating room, in the recovery room, in central supply, and on the surgical floors. Although the program's emphasis was always on the surgical patient, the importance of "complete cooperation and coordinate care" was conspicuously in the forefront.

The American College of Surgeons, with help in the planning from representatives of the American Hospital Association, the Ohio and National Leagues for Nursing, and the Ohio State Nurses Association, put on one of the most productive clinical programs it has ever been our privilege to report. There is no doubt about it—this group recognizes nurses as professional partners on the surgical team . . . and has taken

EDITORIAL

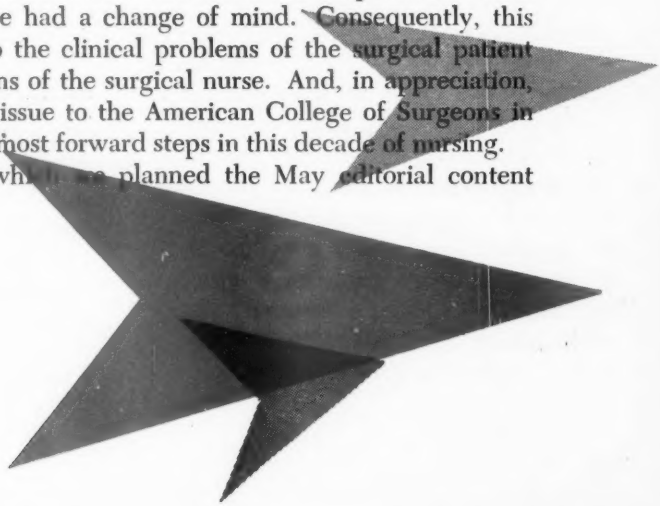
the initiative in helping to make nurses better qualified members of that team. Dr. H. Prather Saunders, associate director of the ACS, in announcing the meeting said, "We believe that nurses are interested in the clinical problems and that their interest in the care of patients will be increased by helping them to know more about the conditions for which the patient is under treatment."

The response to the American College of Surgeons' invitation to nurses to be its guests at this meeting was overwhelming. At least it almost overwhelmed the program arrangers who, expecting a few hundred, were inundated when the nurse attendance soared over a thousand. There is no doubt that there will be more joint meetings of this type in the future.

The enthusiastic reception of this clinical program by those nurses who attended only confirmed our belief that the professional associations and nursing journals, in particular, can do a great deal more in informing nurses of developments in clinical fields.

In the past, **R.N.** has purposely not gone too deeply into the clinical areas of nursing. But, since the panels and papers presented at this meeting evoked such intense interest and gave us proof positive that nurses are hungering for more information that will help them in their clinical practice, we have had a change of mind. Consequently, this entire issue is devoted to the clinical problems of the surgical patient and the practical problems of the surgical nurse. And, in appreciation, we dedicate this special issue to the American College of Surgeons in recognition of one of the most forward steps in this decade of nursing.

The nucleus around which we planned the May editorial content



was the three-hour panel on the "Responsibilities of the Nurse in Fluid and Electrolyte Therapy," which was presented at the ACS meeting by the Ohio State University's Department of Surgery and the School of Nursing and Nursing Service.

In addition, **R.N.**'s pharmacology consultant contributes an article and a Drug Digest on the various solutions and drugs employed in the management of the surgical patient; our Janet Geister writes of the surgical nurse; a private duty nurse describes the nursing care of a patient with severe chest injuries; the psychological aspects of surgical patient care are considered by a psychiatrist who spoke inspiringly at the ACS meeting; and the functions and problems of the operating room nurse are highlighted in an **R.N.** panel which was recorded at the last meeting of the Association of Operating Room Nurses.

It is superfluous to say, that as editors who want to educate, entertain, and bring the best to our readers, we are figuratively sitting on pins and needles until we know of your response to this surgical symposium.

Again we reiterate, this is a special issue—done only because we believe the occasion warrants it. However, we would appreciate an expression of opinion from our readers as to its merit and as a guide to whether or not we should be considering the inclusion of more clinical articles in future publications.

THE EDITORS

INTRODUCTION

■ On the following pages is a "Forum on Fluid and Electrolyte Therapy" based on papers presented by the Department of Surgery and School of Nursing and Nursing Service of Ohio State University at a nurses' program of the American College of Surgeons' meeting in Cleveland.

The first article, "The Physiology of Fluid Balance," is abstracted from a paper by Robert N. Watman, M.D., assistant professor of surgery. "Maintaining the Patient's Fluid Balance," is a compilation of papers given by Jacob Jay Jacoby, M.D., professor of anesthesia, Ann Buckeridge, R.N., assistant professor, school of nursing, H. William Clatworthy, Jr., M.D., associate professor of surgery, and Thomas Boles, M.D., assistant professor of surgery.

"The Technique of Intravenous Therapy," is derived from a paper by Ann Shanck, R.N., supervisor of surgical specialties in the nursing service. The chart on solutions and medications for intravenous therapy was prepared by Jean McArdle, R.N., instructor at the school of nursing. Rounding out this forum is an article and Drug Digest on solutions and medications for the surgical patient by "R.N.'s" pharmacology consultant, Morton J. Rodman, Ph.D.

FORUM ON FLUID AND ELECTROLYTE THERAPY

PHYSIOLOGY of F

■ THE HEALTHY person pays little attention to his daily intake and output of fluids. He doesn't need to, for these amounts are regulated for him by mechanisms in his body that maintain a nice balance between fluid intake and fluid loss.

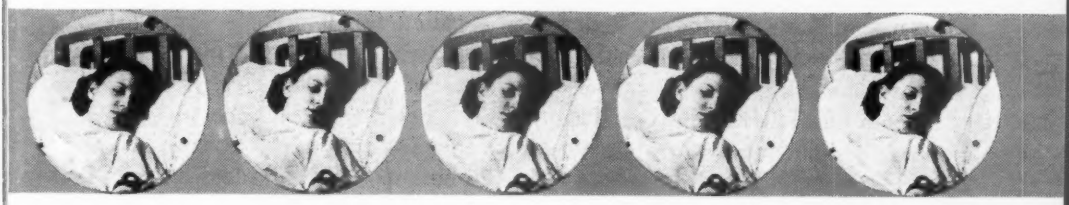
For example, we drink because we are thirsty. And if we do drink too much or too little, we have a remarkably helpful kidney that minimizes the indiscretions and, within reason, adjusts output to intake. Normally in a day we excrete about 1000 cc. to 1500 cc. of urine and lose about 1000 cc. of respiratory water and sweat, so it stands to reason that fluid intake must match fluid loss.

If the fluid composition of the body were solely water, our physiological needs would be simple. But when we speak of body fluids we have to consider them as solutions of colloid and electrolyte. Colloid refers to solid particles that are unable to pass through cell membranes because of their large molecules.

The importance of colloidal solutions may be seen in the human body where the blood holds some substances in true solution and others in colloidal solution. Only the substances in true solution, such as sodium chloride, can enter the cells or leave them. On the other hand, the serum proteins, which are colloidal particles, cannot leave the blood plasma, and this is a good thing, for they help to maintain fluid equilibrium by drawing extracellular fluid back into the blood vessels. It is also fortunate that colloidal particles such as glycogen and cell proteins cannot leave the cells because they are needed there for cellular activities.

What of the solutions of electrolytes that we hear so much about today in the postoperative care of our patients? Perhaps the simplest way to explain electrolytes is to describe them as acids, bases, and salts, and the only compounds whose water solutions conduct electric current. Other compounds, such as sugars and alcohols, are called non-

f FLUID BALANCE



electrolytes because their solutions do not conduct an electric current.

If our electrolyte intake should be inadequate, the altered body fluids would bring about certain compensatory changes in order to retain electrolytes and increase their intake. Normally, there is taken in and lost each day about 100 milliequivalents* of sodium, potassium, and chloride, and enough of the other electrolytes.

Body fluids are in a constant process of exchange with each other, and all of their components are constantly shifting. Yet there is a dynamic equilibrium; so that, in spite of all the movement, the fluid compartments maintain a fairly constant composition.

If this mechanism of fluid balance were self-contained from birth to death, it would attract much less attention. But, unfortunately, it is in contact with the outside world and in exchange with it as well. And it is this contact and exchange which create most of the problems encountered in surgery.

The simplest type of interference with the fluid equilibrium is the inability of a patient to take water and electrolytes by mouth. In this case, all of the compensatory mechanisms become active, but some loss is in-

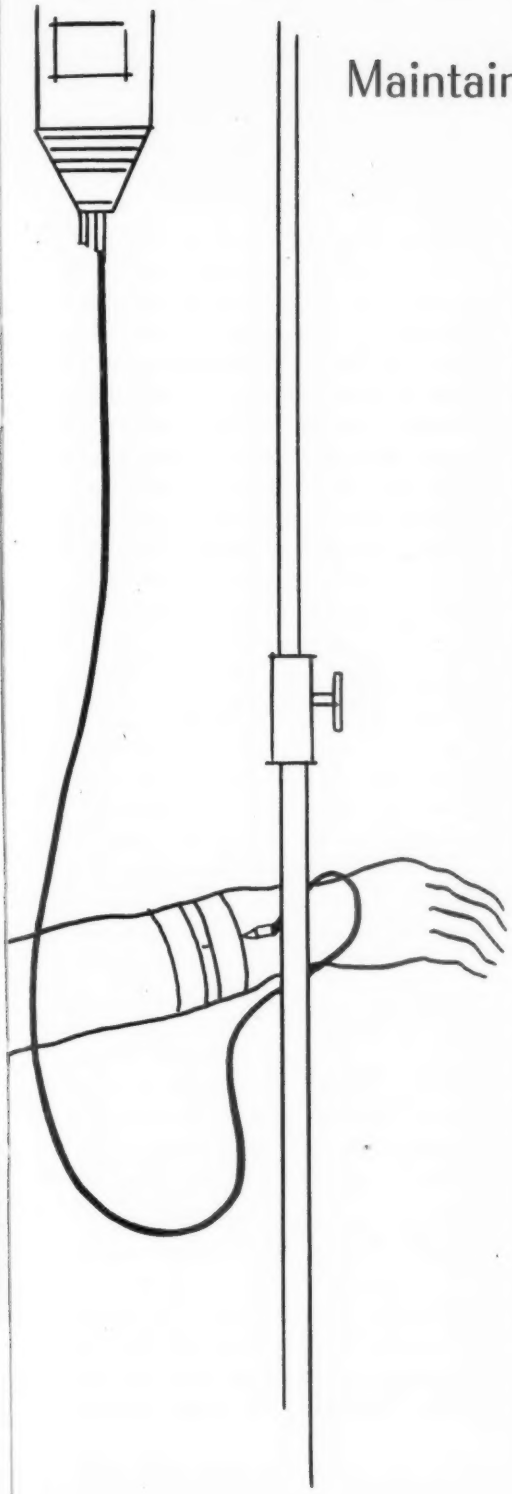
*In the metric system, the milliequivalent is derived by dividing milligrams per liter by atomic weight, and multiplying by valency. Concentrations of electrolytes must be expressed in terms of chemical equivalence for purposes of comparison.

evitable, and the organism gets out of kilter rather rapidly. Ultimately, the loss of fluid has about the same effect as loss of blood, and the blood volume may be reduced to the point of shock. Fortunately, this condition is easy to correct. Since we know the losses and the usual intake, the right amount of fluid can be given by some parenteral route. We call this type of fluid-need the *normal daily requirement*. At present, the entire approach to fluid and electrolyte therapy is based on the assumption that what is normal is desirable in most cases. However, it may well be that future research will reveal that the fluid and electrolyte composition of the normal individual isn't the best for the patient with intestinal obstruction, pneumonia, or some other disease process.

Patients may also lose an abnormal amount of fluid and electrolytes through a fistula, a Levine tube, vomiting, or diarrhea. In other words, fluid which ordinarily would be reabsorbed by the body is now lost. The losses may be very large—for example, the loss of gastric secretion and saliva through a Levine tube may be several liters a day. This type of loss may be called *abnormal loss*. Obviously, the fluid and electrolytes lost in this manner must be replaced, and well-planned replacement is based on careful measurement of the loss.

Many patients are first seen after they have already fallen out of proper balance. And here it is not enough to keep up with current losses—the fluid already lost must be replaced rapidly or slowly as the situation demands. This need may be called the *deficit*.

These, then, are the physiological bases of fluid and electrolyte therapy underlying the recognition and proper estimation of the minimal requirements, abnormal losses, and deficits. All of the problems associated with this type of therapy may be critically important and are often very difficult. But the methods and principles of solving them remain the same, and the checks on the situation remain the same: output of urine, clinical condition, and analysis of body fluids.



Maintaining the Patient's Fluid Balance

■ BEFORE THE fluid needs of the surgical patient were recognized by surgeons, the administration of parenteral fluids was a rarity in operating rooms and on the wards. Now the solution bottle and standard is a familiar part of the surgical scene.

Parenteral therapy is also used widely in children's hospitals where continuous venoclysis is a common procedure. In children, as well as in adults, the intravenous route is used not only to restore blood volume, provide water, electrolytes, and foodstuffs, but also to administer a wide variety of intravenous medications which are used in the treatment of disease.

Administration of medication in the O.R. is frequently done by the intravenous route, and, during most minor operations, I.V. fluids are given chiefly to keep the needle open for the injection of medication. For operations lasting over an hour, I.V. fluid is given either because the patient has had no fluid by mouth for several hours or because he will probably not take fluids by mouth for several hours after surgery.

Fluids for the postoperative period should be ordered by the physician immediately after surgery. But if there are no additional orders for fluid available when the patient arrives in the recovery room or on the ward with a bottle of fluid that is almost empty, the nurse should attach a bottle of 5 per cent dextrose

in water and continue to give this until further orders are obtained from the doctor. A solution of 5 per cent dextrose in distilled water is the standard fluid for use in the operating room, but other solutions may be given when special indications exist.

The average rate of administration of the I.V. solution should be slow enough to avoid overloading the circulation and fast enough to avoid unnecessarily prolonged restraint of the patient. The average rate for clear fluids for the adult is 500 cc. per hour, 8 cc. per minute, or two drops per second. The administration of one liter of fluid should take two hours.

An important point to note is that I.V. fluids must be given slowly to small children and patients who are elderly or who have heart disease. In the case of infants, it is generally considered safe to administer 10 cc. of electrolyte or colloid fluid per pound of body weight up to a maximum of 250 cc. rapidly (within 30 minutes).

In order to avoid overloading the circulation, some children's hospitals have discontinued the use of the standard 250-500-1000 cc. flasks for infants weighing less than 25 pounds. Instead, fluids, electrolytes, etc., are mixed in open mouth, 300 cc., salvarsan-type burettes which never contain more than 10 cc. per pound of body weight. Similarly, whole blood, which is customarily supplied by blood banks in 500 cc. flasks, is divided into individual transfusion bottles containing the amount required for one transfusion (10 cc. per pound), before it is administered to small children.

Rapid administration of blood, plasma, plasma extenders, or other fluids is needed for people who are in shock, or who are actively bleeding. Transfusions in the operating room may have to be very rapid in order to keep up with the blood loss. Blood is usually administered by means of a gravity drip, but if this is not rapid enough, compressed air or oxygen may be used to pump the blood into the circulation.

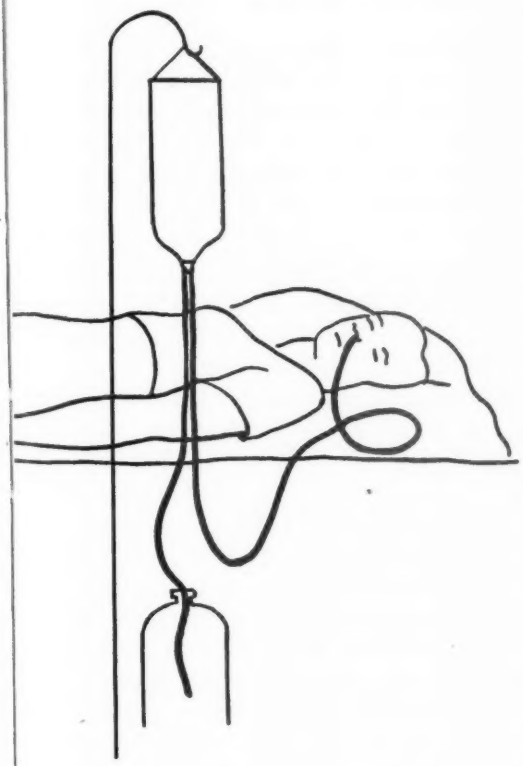
Blood is given in the operating room for anemia and blood loss. For the treatment of anemia no more than one pint of blood should be given during the operation for fear of overloading the circulation. However, in active bleeding during surgery, blood should be administered in amounts equal to the blood loss.

The quantity of blood loss is determined by measuring the amount in the suction bottle, weighing the sponges (each gram of additional weight represents approximately one cc. of blood lost), and estimating the quantity of blood on the drapes and floor. The latter amount usually adds 20 per cent to the measured blood loss.

In caring for the patient during the immediate postoperative period, the nurse must be sure that his breathing is adequate and unobstructed. This is of *primary* importance. Attention must then be directed to the administration of fluids. The needle in the vein should be kept open, and special signs of circulatory difficulty that might call for

a change in the administration of fluids should be watched for. These include excessive bleeding, a drop in blood pressure, or a rise in the pulse rate. If any question arises, the physician, surgeon, or anesthesiologist should be called.

Although I.V. fluids are given almost routinely in surgery, the intravenous route is a dangerous one, and especially so when patients are unconscious, for signs of a reaction, such as chills, fever, and other pyrogenic reactions may be obscured. Also, there may be an air embolism caused by a leak in the infusion set, or by compressed air or oxygen if the blood bottle should empty while blood is being pumped into the veins. The risk to the patient who has any reaction to I.V. therapy is enough to call for immediate discontinuance of the infusion.

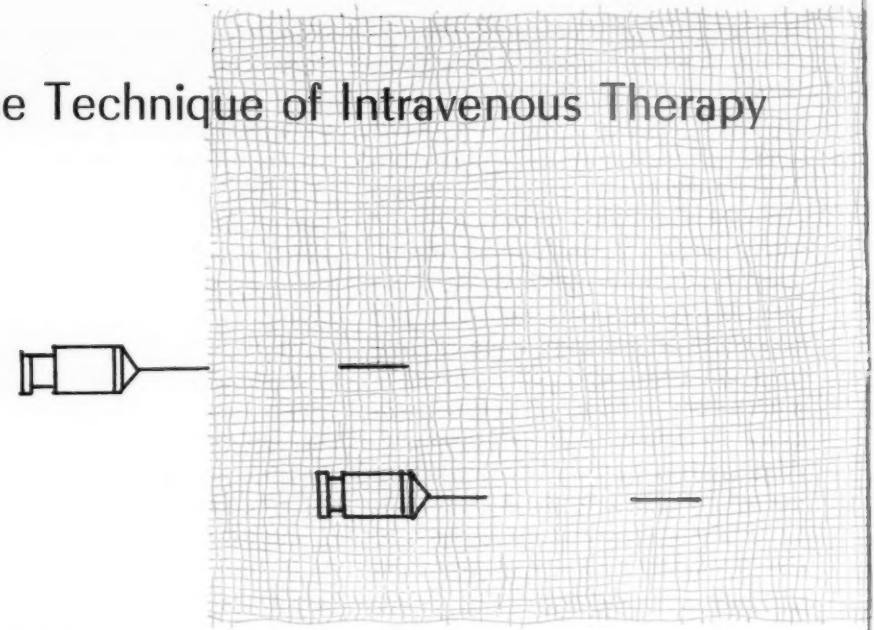


A local reaction may arise at the site of the insertion of the needle and the surrounding tissues. In the early stage of this reaction, there may be swelling and discoloration. After the needle is removed, pressure should be applied to the affected area. In the event of infiltration with swelling and blanching of the tissues, heat should be applied and the limb elevated. This same treatment is indicated in the late local reactions of necrosis and thrombophlebitis. (Necrosis is marked by tissue sloughing and ulceration, and thrombophlebitis by redness and pain along the venous pathway.)

Systemic reactions may also follow intravenous administration. The allergic reaction, characterized by itching and redness of the skin, and hives, is usually helped by Adrenalin and antihistaminic drugs such as Benadryl and Pyribenzamine. There is also an incompatible or accelerated allergic reaction associated with whole blood transfusions. This is indicated by bleeding (oozing) of surgical wounds, hemoglobinuria, and kidney shut-down. In treating this condition, the physician may resort to the use of Adrenalin and antihistaminic drugs.

In addition, there may be a pyrogenic reaction with headache, malaise, chills, and fever, and an anaphylactic reaction which may be associated with [*Continued on page* 75]

The Technique of Intravenous Therapy



■ INTRAVENOUS THERAPY is so widely employed today that nurses must have a thorough understanding of the proper technique in its management. There is still some controversy as to whether nurses should actually give I.V. infusions, but there is no question as to the nurses' responsibilities in the overall intravenous treatment. Whether they insert the I.V. needle or not, they must be familiar with the technique of administration, consider the comfort of the patient, and record accurately the patients' fluid replacement and losses.

Nurses who are responsible for I.V. therapy will need to know about the proper sterilization of equipment and the hazards associated with the use of unsterile syringes and needles, particularly the danger of homologous serum hepatitis. The usual I.V. equipment consists of: a flask of solution; tubing and needle; well-padded splint; alcohol sponges; intravenous standard; adhesive tape; dry sponges; and possibly a syringe.

In selecting a needle for the venipuncture, remember that a sharp point is most important. Dull needles make venipunctures very difficult and painful. Test the needle by appearance and by brushing the point over a dry sterile gauze pad. The caliber, length, and bevel of the needle used will vary with the fluid employed and the site of the venipuncture.

After the equipment is set up and found to be in good order, the next step is the selection of the venipuncture site. The vein that doctors prefer to use is located on the flat surface of the forearm. If this is not

suitable, the veins—in order of preference—are those on the dorsum of the hand (except for irritating substances); the greater saphenous vein at the ankle—the preferred site for continuous cut-down infusion; and those on the antecubital fossa.

If the vein is not readily visible or palpable, a soft rubber tourniquet may be applied to make the vein more prominent. Using a blood pressure cuff and running the sphygmo-

manometer up to 10-15 mm. below the patient's diastolic reading may achieve the same purpose. Other methods followed by those versed in venipuncture are slapping lightly the surface of the vein, pumping the patient's hand, applying moist heat over the vein's surface, and arranging the arm so that it is in a dependent position.

After the skin is cleansed in the prescribed manner, the actual venipuncture can be performed. Holding the skin with little or no flexion, the needle is thrust through the skin at a 35-45 degree angle. The needle is then realigned parallel with the vein for the thrust into the vein. There may be pain if the needle goes too deeply, or a hematoma may arise if it goes through the vein. If there seems to be an occlusion, the bevel of the needle may be pressing against the wall of the vein.

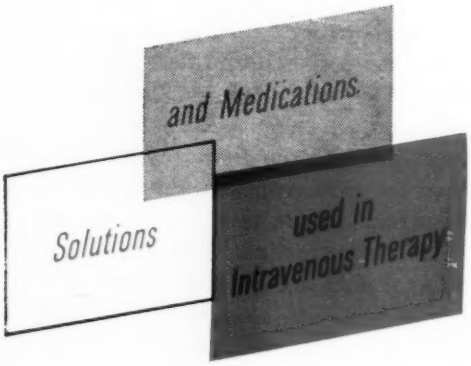
When the needle is properly in place, anchor it to the skin with adhesive tape in at least three places, being certain that the hub of the needle is against the skin. Use a splint if the needle is located other than in the forearm or the foot. Splints are also indicated for patients who are unconscious or combative, or for infants and children. Unnecessarily tight straps, restraints, and unpadded splints should be avoided. Always provide a loop of tubing between the flask and the needle so that a tug on the tubing

won't dislodge the inserted needle.

The most important role of nurses in intravenous therapy is supervision. The rate of flow must be checked frequently, for there are many factors that can affect this rate. For instance, the flask may not be at the proper height; the patient may shift in bed; or the restraining tapes may be too tight. There may also be evidence of infiltration or hematoma, or occlusion of the needle. If the latter occurs, obstructive material should not be pushed into the vein.

Since doctors rely on nurses for an accurate record of I.V. therapy, it is imperative that nursing personnel accurately [*Continued on page* 84]

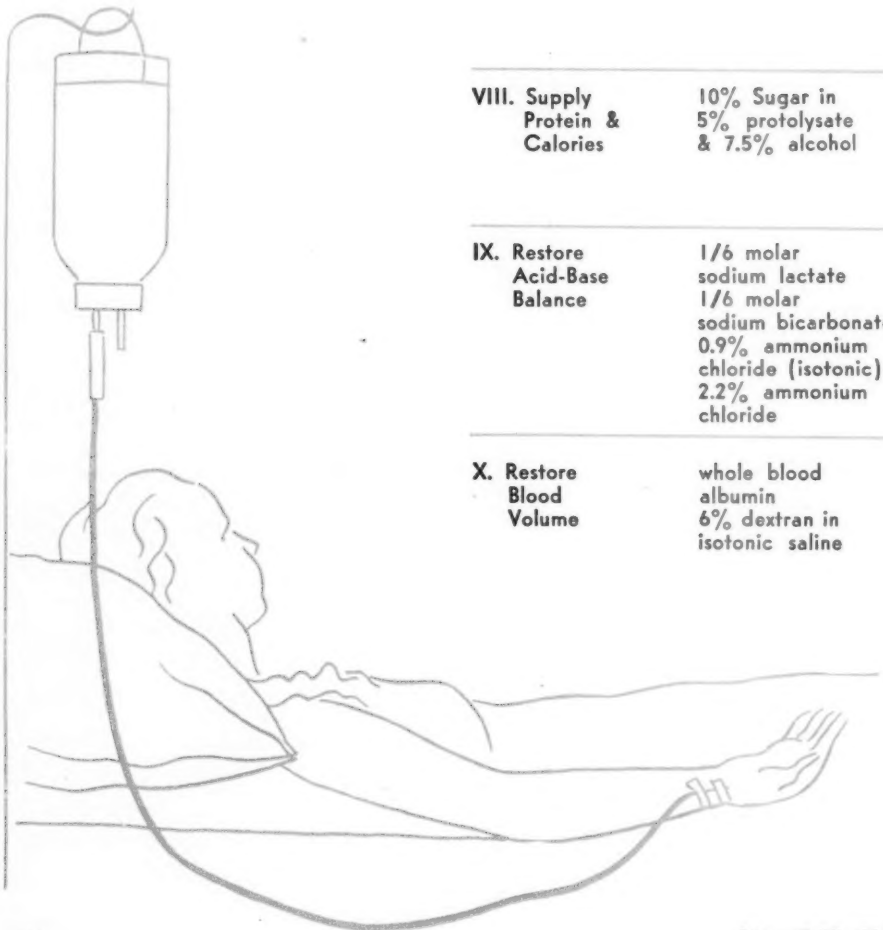
Intravenous solutions are ordered to meet specific needs of individual patients. Generally, the purposes of I.V. therapy are to: maintain or replace body stores of water, electrolytes, vitamins, calories, and protein; restore acid-base balance; restore blood volume; and provide a vehicle for I.V. medications. The table at the right contains examples of solutions and medications commonly used to achieve these purposes.



PURPOSE	SOLUTION
I. Hydration	5% dextrose in water
II. Hydration Salt Replacement	5% dextrose in saline
III. Supply Potassium	potassium chloride
IV. Supply Nutritional Supplements	vitamin B complex vitamin C
V. Supply Calories	5-10% dextrose, fructose, or invert sugar (equal parts dextrose & fructose)
VI. Supply Calories & Sedation	5-7.5% alcohol in 5% dextrose

USE	COMMENTS
1. Supplies water in an isotonic solution. 2. Spares protein by providing 200 calories. 3. Decreases ketone formation.	1. The 200 calories in 1000 cc. are sufficient to spare protein from being burned for energy and to keep patient out of acidosis, but will not meet minimum caloric needs.
1. Replace salt when losses occur through vomiting, G.I. suction, diaphoresis.	1. If used where salt replacement not specifically indicated, kidney has extra burden of selecting & retaining what body needs & excreting the excess. Therefore, in order to prevent edema, saline should be used with discretion: a. in kidney disease. b. where kidney able to excrete only limited amount of sodium. 1) 1st 24 hrs. after surgery. 2) in elderly patients. 3) in prolonged illness.
1. Replace potassium losses which occur with major surgery, vomiting, G.I. suction, diarrhea, G.I. fistulae, dehydration, diabetic acidosis, ACTH and cortisone therapy.	1. Give slowly in dilute solution to prevent symptoms which occur if serum level too high: a. Paresthesia of hands and feet. b. sudden weakness in extremities. c. shock-like symptoms. d. cardiac arrhythmias (watch pulse). 2. Check urinary output as guide to kidney function to prevent accumulation of potassium in blood stream. (Therapy safe if kidney able to excrete excess.)
1. Vitamin B, especially thiamine, aids in carbohydrate metabolism when glucose given. 2. Vitamin C aids in wound healing.	1. Water soluble vitamins excreted in urine unless: a. given slowly in dilute solution. b. body requires vitamins. 2. Because of rapid excretion & expense, vitamins should be given only if patient fasting 3 days or longer.
1. 10% solution supplies twice as many calories (400) as 5% (200). 2. Fructose & invert sugar especially useful where more rapid utilization is desired as in diabetic acidosis.	1. 3000 cc. of 10% solution supplies only 1200 calories (¾ths of body's basic needs at rest). 2. 10% solutions given rapidly act as diuretic. 3. All hypertonic solutions are irritating to veins. May cause sclerosis & thrombophlebitis.
1. Supplies 480-620 calories per liter. 2. Reduces need for narcotics thru mild analgesic & sedative effect when patient: a. sensitive to narcotics. b. young and able to tolerate alcohol.	1. Watch constantly older patients, especially for signs of restlessness, excitement, or inebriation. 2. Give slowly (150-200 cc. per hour). 3. Watch for tissue damage with infiltration.

PURPOSE	SOLUTION
VII. Supply Protein	5% protolysate (e.g. Amigen) in dextrose
	albumin (25 Gm. per 100 cc. vial)
VIII. Supply Protein & Calories	10% Sugar in 5% protolysate & 7.5% alcohol
IX. Restore Acid-Base Balance	1/6 molar sodium lactate 1/6 molar sodium bicarbonate 0.9% ammonium chloride (isotonic) 2.2% ammonium chloride
X. Restore Blood Volume	whole blood albumin 6% dextran in isotonic saline



USE	COMMENTS
1. Provides 37.5 Gm. protein per liter when G.I. tract must be rested over prolonged period for: a. replacement specific losses. b. building material. c. tissue repair.	1. Give with adequate calories, or protein will be utilized for energy instead of replacement. 2. Give only 2 liters per day. 3. Expensive. 4. Precautions: a. Watch for allergic reactions. b. Watch for pyrogenic reactions (headache, flushing, nausea & vomiting). c. Use immediately after opening since excellent culture medium. d. Watch for precipitation when adding medications. e. Use separate tubing when preceded or followed by blood.
1. Replace specific losses of plasma albumin only such as in surgical shock, hypoproteinemia, burns. 2. Restore blood volume by maintaining osmotic pressure.	1. Caloric content minimal. Therefore, cannot use as nutritional supplement. 2. More expensive than protolysates. 3. Dilute in 500 cc. dextrose in water or give at slow rate (1 vial in 45 min.) in order to prevent pulmonary edema.
1. When total replacement necessary, 970 calories & 37.5 Gm. of protein supplied per liter: a. with adequate calories, protein used for tissue replacement & b. glycogen store replenished.	1. Use only in depletion because of: a. time required due to alcohol (6½ hours). b. need for constant supervision. c. expense. d. danger vein irritation (hypertonic solution).
1. Supply sodium without chloride in acidosis. 2. Provide excess chloride to combat alkalosis.	These solutions are usually unnecessary in the correction of acid-base problems. They are used only rarely and with specific indications.
1. Increase blood volume & sustain blood pressure in emergencies because: a. large molecules similar to plasma remain in circulation longer than glucose or saline. b. can be mass produced & readily available.	1. Does not contain protein or red blood cells so cannot substitute for blood. 2. Precautions: a. watch for pulmonary edema with heart & kidney disease. b. watch for occasional allergic reactions (mild urticaria, rare wheezing, nausea & vomiting).

by Morton J. Rodman

■ SOLID CITIZENS may be startled to learn that water accounts for about two-thirds of the weight of their bodies. Not only does each of the body's billions of cells contain water, but all are bathed by an ocean of surrounding fluid. This "sea around us" is, in fact, a solution similar in its salt content to that of the ancient seas in which the earliest organisms developed.

Because cell survival depends on this internal environment being kept constant, the human body has many mechanisms for maintaining an exact balance between the proportions of water and dissolved solids in its cells and fluids. Normally, these complex physical-chemical adjustments and exchanges go on so smoothly that we are quite unaware of their existence and importance. Sometimes, however, under unusual stress such as surgery, trauma, burns, and disease, various of these functions may fail. The derangements in water and salt balance that result can be disastrous, unless deficiencies are quickly corrected by procedures for maintaining and replacing body fluids and salts, until the pathological processes can be overcome.

While physiologists have long been aware that distortions in the distribution and chemical content of the body fluids could interfere fatally with tissue function, medical men have been slow to apply this knowledge to the care of acutely ill patients. Recent research, however,

has stimulated a revival of interest among clinicians and surgeons in the relationship of body fluid chemistry to health and disease.

Fundamental facts revealed by such electronic-age tools and techniques as the flame photometer, spectrophotometric colorimeter, and isotope dilution studies have now made it possible to manage fluid imbalances rather readily on a scientific basis. This new knowledge is being widely applied at present to practical problems in the care of seriously ill patients, especially in the period immediately after surgery.

The rational use of parenteral solutions for correcting the composition of body fluids deranged postoperatively and in various pathological conditions requires an understanding of certain basic physiological principles of water and mineral metabolism. Thus, for example, since water balance disturbances are marked by an abnormal shift in body water distribution, we ought to know how this water is normally divided.

Body fluids are contained in three characteristic compartments separated from each other by semipermeable membranes that permit some substances to pass through, while holding back others. The cell wall serves as one such barrier and the capillary lining as another. Water within the cells makes up about three-quarters of the total and blood plasma about one-tenth; the rest, caught between the cells and the vascular tree, is called the interstitial fluid.

While all the intracellular and extracellular fluids contain similar salts, acids, and bases, the concentration of these electrolytes in the different compartments varies considerably. Inside the cell, potassium and magnesium are the predominant positive ions, and sulfate and phosphate are the chief negative ions. The blood plasma and the fluids in the other extracellular areas are high

in sodium, chloride, and bicarbonate electrolytes.

While nutrients and wastes are being exchanged constantly between the blood and the tissues, the composition of the several fluid compartments normally remains remarkably constant within narrow limits. This is due to the automatic activity of certain complicated compensatory mechanisms put into play by any kind of emergency that threatens to upset the delicate balance. Even the simple act of drinking a glass of water sets off a chain reaction of almost unbelievable complexity involving hormonal and nervous influences that let the body keep exactly what it needs and get rid of the rest.

Unfortunately, despite the efficiency of these regulatory mechanisms that help us retain essential substances and excrete those that are in excess, their capacity for adjustment is not unlimited. When these limits are exceeded, as they often are in disease and under extremes of environment, the fine balance between intake and output of fluids is broken. The body may then be rather rapidly drained of substances it needs for normal function, or overloaded with wastes that interfere with vital processes.

This occurs most commonly in kidney and gastro-intestinal disease, or after burns, trauma, and surgery. To prevent and overcome the dehydration and ionic and acid-base imbalances that often accompany and complicate these conditions, the parenteral administration of fluids, foods, and electrolytes in proper amounts and concentrations may be required. Not only must the deficit due to abnormal losses and reduced intake of water and minerals be accurately determined and rapidly replaced with a like quantity, but calories, proteins, and vitamins must also be supplied at a suitable rate for replacement and maintenance when the patient can't take these necessary substances by mouth.

What then are some of the clinical conditions requiring parenteral therapy, and what precautions must be observed in giving the various solutions and medications that are commonly used in such treatment?

Dehydration due to excess loss of water alone is the most common and least complicated condition encountered clinically. It may be treated simply by determining the water deficit and replacing it with a like quantity. If the water loss is allowed to continue, however, vital alkaline elements may also be excreted in excess as the kidney tries to keep the tissue salts and water in balance.

Water is usually given parenterally in the form of a 5 per cent glucose solution, because injection of plain, distilled water can cause red corpuscles to swell and burst when osmosis draws the fluid into the corpuscles. The sugar serves to prevent such hemolysis by equalizing the osmotic pressure. It acts also as a source of energy, supplying some of the body's calorie requirements. This lessens the tendency toward tissue breakdown and acidosis that can occur when the body has to

burn its protein for necessary energy.

Most cases of clinical dehydration need salt as well as water, because both are lost in prolonged vomiting, diarrhea, gastro-intestinal suction or sweating. Here, hydration alone is not enough and may even cause toxic symptoms if tissues become water-logged. Muscle cramps, tremors, and even convulsions can occur if water intake and salt loss are both excessive.

In such cases, isotonic saline solution is indicated to replace the body's store of sodium. Such salt solutions stay out of the tissues and in the extracellular spaces and the plasma where they are most needed. To avoid the possibility of peripheral and pulmonary edema, saline should be administered with caution to patients whose kidneys cannot readily excrete the excess sodium that is taken in.

It is now known that another ion to be- [*Continued on page* 76]

Probie

"At least they don't say 'ouch.' "

Drug Digest

FRUCTOSE N.N.R. (Parenteral Alimentation)

PROPRIETARY NAME: Levugen

PHARMACOLOGY: Fructose (levulose) is used to furnish carbohydrates and fluids by vein to patients who cannot take adequate amounts of food and water by mouth. Less fructose is lost through renal excretion than occurs with dextrose, due to the greater rate at which it is metabolized and turned into liver glycogen.

DOSAGE: A 10 per cent solution can be given safely by vein at a rate as rapid as a 5 per cent glucose solution due to the fact that fructose is less likely to disturb bodily fluid balance. The maximum amount given daily to adults is 3 liters; children's dosage is based on size and blood volume.

UNTOWARD ACTIONS: Fructose is non-toxic, but, as with other parenteral solutions, too rapid administration of intravenous solution should be avoided. Other substances which may turn the solution alkaline should not be added as these may decompose the fructose.

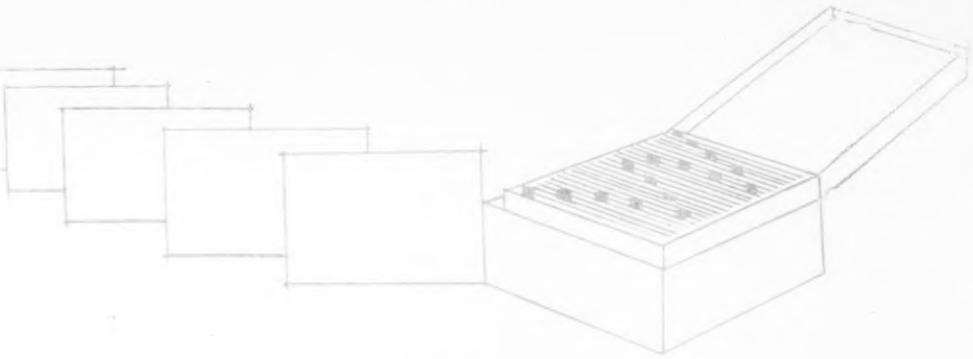
POTASSIC SALINE (DARROW) N.N.R. (Parenteral Fluid)

PROPRIETARY NAME: Solution Potassic (Darrow)

PHARMACOLOGY: This dilute solution of potassium chloride, sodium chloride, and sodium lactate is indicated in the treatment of dehydration complicated by acidosis and low levels of plasma potassium. It is especially useful in infants and others severely dehydrated by diarrhea.

DOSAGE: The solution is given by hypodermoclysis or by venoclysis at a relatively slow rate. A maximum of 80 cc. per kilogram of body weight is given over a period of eight to twelve hours. For infants, the solution should be diluted with two parts of 5 per cent glucose solution.

UNTOWARD ACTIONS: The solution should be given with caution, especially to patients with poor circulatory or kidney function. To guard against the depressant action of potassium on the heart, frequent electrocardiographic records should be made as well as determinations of the amount of potassium in the blood. The concentration of this ion should be kept below 20 mg. per 100 cc. of blood.



DEXTRAN N.N.R. (Plasma Extender)

PROPRIETARY NAMES: Expandex, Gentran, Plavolex

PHARMACOLOGY: Dextran is a glucose polymer with an average molecular weight of about 75,000, which makes a 6 per cent saline solution with an osmotic activity similar to that of serum albumin. This solution is given intravenously to increase plasma volume lowered by hemorrhage or in shock due to trauma.

DOSAGE: About 500 cc. of the solution is usually injected over a period of fifteen to thirty minutes and may be repeated if necessary. Dextran should not be used as a substitute for whole blood in anemia following hemorrhage, and plasma proteins are preferred in edema secondary to protein deficiencies.

UNTOWARD ACTIONS: Except for causing occasional mild allergic reactions, properly prepared dextran injections appear to be free of side reactions.

PROTEIN HYDROLYSATES N.N.R. (Parenteral Alimentation)

PROPRIETARY NAMES: Amigen, Aminosol, Hyprotigen, Parenamine, Protolysate

PHARMACOLOGY: These are parenteral preparations that supply amino acids for maintaining nitrogen balance in patients unable to digest or absorb protein foods, especially during severe sickness and after operations on the gastro-intestinal tract.

DOSAGE: The dose is based upon the requirements of the individual which may vary widely. About 70 grams of protein is considered adequate for supplying the needs of the average adult male for amino acids. These protein digests must have more than half of their nitrogen in the form of alpha amino acids.

UNTOWARD ACTIONS: Undesirable reactions can occur if these solutions are given intravenously during acidosis, too rapidly, or by means of inadequately cleaned equipment. These untoward effects include nausea, vomiting, abdominal pain, fever, and convulsions, as well as localized edema, phlebitis, and thrombosis.

A SURGICAL M

■ MOST NURSES who work in today's hospitals can testify to the miracles of modern science. In fact, some of us have become so used to recoveries speeded by antibiotics and surgery that we may be somewhat blasé about it all.

Any matter-of-fact attitude that I may have had, though, disappeared last summer when I was called in as a private duty nurse to care for a 51-year-old brick mason who had been crushed against the side of an open hearth furnace by a locomotive.

When the patient was admitted to the Wesley Memorial Hospital in Chicago, he had multiple fractures of the pelvis and clavicle, and serious chest injuries. The crushing impact of the locomotive had broken eight ribs on the left chest and ten ribs on the right chest. Both lungs were punctured.

Because of the extensive chest involvement, the patient could breathe only with the greatest difficulty and could not cough. As a result, secretions were retained, clogging the airways and causing a localized atelectasis which prevented immediate expansion of the lungs. Literally, he was threatened with drowning in his own body fluids.

Paradoxical respiration, the reverse of normal respiration, was also a serious threat. Since the entire chest wall was without bony support, it appeared, on inspiration, to be sucked inward while the abdomen

expanded outward. On expiration, the chest wall ballooned out while the rest of the thorax decreased in size as air was expelled from the lungs.

Ten years ago the chances of saving this patient's life would have been pitifully slim. But this was 1954.

One of the most pressing problems to be solved by the surgeons, in addition to operative repair, was stabilization of the chest wall in order to correct paradoxical respiration and inefficiency of coughing. Using a new method of stabilizing the chest, the doctors inserted three stainless steel Steinman pins into the pectoral muscles on either side of his chest. These pins were connected to wires which ran through pulleys attached to a Balkan frame on the bed. Two-, three-, and four-pound traction applied to the pins pulled the chest wall outward, allowing space for lung expansion within the thoracic cavity. Another means of reducing paradoxical motion and increasing alveolar ventilation is through a tracheotomy. In this case, a tracheotomy was performed and oxygen was administered directly into the inner cannula of the tracheotomy tube.

Other life-saving devices utilized by the doctors included chest tubes inserted in both right and left anterior pleural spaces. These were connected to Chaffin Pratt suction machines. A Levine tube attached to a thermatic suction machine kept the stomach emptied of mucus secretions and air, thus preventing abdominal distention which could lead to respiratory distress. A colon tube was also ordered to reduce flatulence. Because of the hematuria from severe trauma to the kidneys, a Foley catheter was inserted for bladder drainage. Add to these a respirator, and I.V. equipment for giving blood transfusions, plasma, glucose, and saline, and you'll understand why the doctors, during the early stages of treatment, found it difficult to enter the patient's room.

It can readily be seen that the nursing in this case was a challenge to the ingenuity and skills of the three private duty nurses who were responsible for giving this critically

injured patient round-the-clock nursing care.

The nurses' detailed account of the patient's condition and reaction to treatment was extremely important to the doctors. For this particular patient, it necessitated an accurate record of blood pressure, pulse, and respirations every hour for the first three weeks of hospitalization. A rectal temperature was taken every four hours. Fluid intake and output were carefully recorded, as were the character and amount of the aspirated tracheal secretions.

An important nursing duty was the irrigation of the trachea every half-hour with a solution of Alevaire, penicillin, and normal saline to dilute secretions and prevent infection. Tracheal suction, of course, followed irrigation, and many times increased cyanosis and diaphoresis from mucus or a blood clot in the bronchi were the warning signals for more frequent tracheal suctioning.

One of the most serious complications arose when the patient became comatose for 36 hours. Careful examination and laboratory findings revealed the coma to be due to carbon dioxide intoxication from faulty aeration of the lungs.

The patient's breathing difficulties were finally overcome by a new Merck respirator which had previously been used by the department of anesthesia in cardiac surgery only. This machine, powered by electricity, furnished positive pressure and a mixture of pure oxygen plus room air which was pumped into the tracheotomy opening. Up to this time, the respirations had ranged from 32

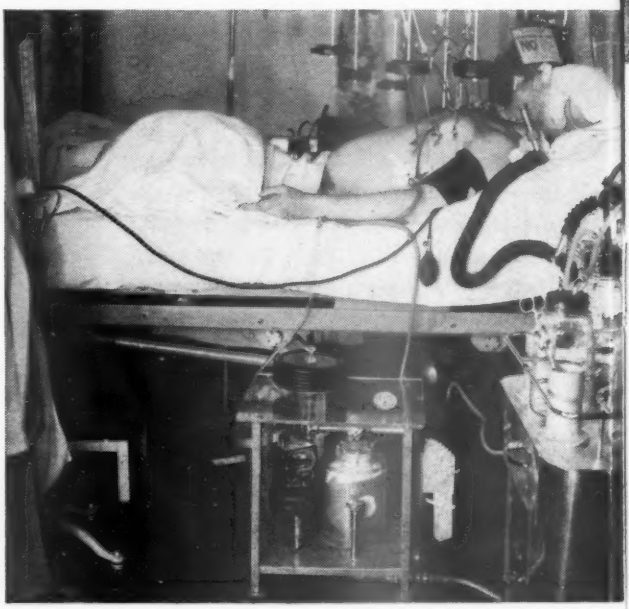


Photo: Chicago Tribune

to 44 per minute, depending on the degree of distress and anxiety of the patient. However, as soon as the patient breathed in time with the machine, the respirations dropped to 24 per minute. The nurses had to see that positive pressure was maintained at 18 to 20 centimeters of water. They also had to be prepared to switch to the use of hand bellows in the event of mechanical or electrical failure.

Through the critical state, the patient was fed amino acids and vitamins in intravenous solutions to maintain adequate nutrition and a normal volume of body fluids. There were two reactions to drugs—a rash from penicillin which responded to Benadryl and a generalized edema which was corrected by ammonium chloride therapy.

In order to promote pleural drainage, the patient's back-rest was placed at a 45-degree angle. This position afforded some comfort as well as relief from cardiac strain. Because of the pulley apparatus attached to his chest, the patient could not be turned from side to side or lifted toward the head of the bed. Since he had to remain in one position for ten days, we had to use our nursing ingenuity in making him as comfortable as possible. An ample measure of TLC (tender, loving care) was an important factor in his recovery.

Although it seemed slow at times, progress was made steadily day by day. When drainage had ceased, the chest drainage tubes were removed on the eighth postoperative day. On the ninth postoperative day, the traction weight was decreased, and both traction and Steinman pins were removed on the twelfth postoperative day when the chest wall seemed fairly well stabilized. Finally, after a two-week period of relative immobility, came the day when the patient could be carefully turned for back care and changes of linen.

In the fifth postoperative week, the patient was permitted to sit in a chair. At this stage, his condition seemed to warrant transfer from a private room to a six-bed ward. There when he was in [*Continued on page* 86]

The Psychological Care of the Surgical Patient

■ "THE NO-MAN'S land of surgery," is how one member of a nurses' panel at the American College of Surgeons' meeting described the psychological care of surgical patients. In making this observation, Dr. Brian Bird, associate professor of psychiatry at Western Reserve University School of Medicine, stated that responsibility in this area is not well defined. Actually, he said, everyone who comes in contact with the surgical patient has a "variable but definite impact" upon his mental life.

Dr. Bird believes, however, that the main responsibility for the surgical patient's mental welfare rests upon the surgeon and the nurse. And because many surgeons may not

have the time or the inclination to attend to this aspect of the patient's treatment, they generally are happy to delegate the job to the nurse.

In order for the nurse to do her part of this job well, she must realize that her role is not the same as the surgeon's. Dr. Bird pointed out that the nurse "serves best if she places herself in a complementary position to the surgeon, tending to aspects of the patient's life which he necessarily disregards."

It is Dr. Bird's contention that the nurse's most important psychological contribution to patient care is not simply comforting patients, but rather keeping open patients' lines of communication. In other words, the nurse should see that the patient is properly informed and that he can talk freely with his surgeon and his relatives. Lines of communication should also be kept open between the relatives and the surgeon, between the nurse and the surgeon, and other personnel.

Because communication problems are encountered so often in caring for the surgical patient who may be affected by anxiety and the strangeness and complexity of his environment, the nurse "should assume that patients will not understand anything the first time they hear it and will have to be told several times." In stressing this point, Dr. Bird cited the case of a patient who was told that her barium enema was "O.K. except for a little defect, which was probably only an area of collapsed bowel." Later the nurse found the patient crying—she was wondering how long she could live with a "collapsed bowel."

According to Dr. Bird, even simple procedures may become confused in the minds of surgical patients, who "are not really unintelligent," but merely "dazed by circumstances." Nurses are well aware of this, for they know that patients may "turn on their stomachs when asked to lie on their backs, or eat what they are not supposed to eat, or use the toilet when they have been told to save specimens."

Another break in communication occurs when the patient is not told of anything unusual under a dressing. Dr. Bird emphasized that "it is better to tell a patient beforehand that a colostomy has been performed than to wait and let him find out at the time of the first dressing." The same would hold true for drainage tubes, open wounds, and unusual incisions.

In many other ways, Dr. Bird noted, the nurse can contribute to the surgical patient's peace of mind. For instance, if an operation is postponed, or scheduled earlier than expected, she should explain these irregularities. Relatives should also be fully informed of what is going on. And they should be warned, too, of what to expect when the patient returns from surgery. If they aren't, said Dr. Bird, they may be alarmed by such unfamiliar sights as a tracheotomy tube or blood transfusion equipment.

Considering what they must go through, Dr. Bird believes that it is remarkable how well patients with-

stand surgery. These patients have "a tightening of self-control, an increase in bravery, a dulling of perceptions, an emotional apathy, a denial of illness, and sometimes even a false cheerfulness. This reaction," according to Dr. Bird, "tends to bring about a state of calmness." This "may almost be regarded as a self-hypnosis, which, like an anesthetic, prepares the patient for the ordeal he must go through."

This calmness of the surgical patient may be deceiving, though, for it means that "he has so many painful feelings that he inhibits them all." The most common of these feelings are anxiety, sadness, and anger.

In Dr. Bird's opinion, the primary mental reaction is intense anxiety. " . . . the surgical patient is scared stiff—he is afraid of the surgical procedure and every aspect of it, afraid of pain, of the anesthetic, and of disfigurement. He is afraid of being helpless, of having his modesty transgressed, afraid of showing fear, afraid of a thousand things. Above all, he is afraid he will die."

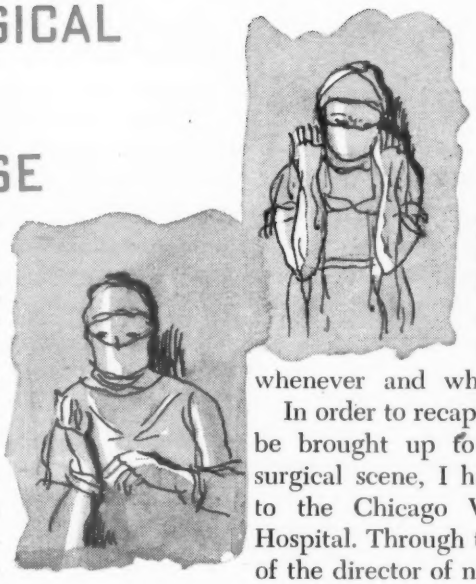
When this fear is expressed openly it is not too difficult to handle through reassurance and sedatives. But Dr. Bird showed more concern over the development of a state of apathy in response to anxiety. "The danger in this response," he said, "is that in giving up fear, the patient gives up everything else as well, including hope. And a hopeless patient is not a good operative risk."

Dr. Bird has found that the second most important feeling in the surgical patient is sadness. Ordinarily, this feeling is not severe but, in certain cases, it may lead to a clinical depression, characterized by feelings of guilt and worthlessness. The presence of these two latter symptoms "is a sign that the patient may commit suicide." Dr. Bird reported that the feeling of sadness, appearing as a sense of loss, was found most frequently in patients whose surgery involved the removal of body organs. Plastic operations were said to be disturbing, too, and are frequently accompanied by a feeling of disappointment.

The anger that "is commonly present" in surgical patients "is usually well-hidden," because it "is so unacceptable to both patient and surgeon." However, Dr. Bird contends that the methods used to conceal this anger may be more damaging than the anger itself. "Whenever a patient becomes 'difficult' or whenever a patient tends to make the staff angry with him, it should be suspected that the patient himself is angry and is hiding behind confusion."

What about the treatment of mental states that may follow surgery? In Dr. Bird's opinion, most "are self-limited and will gradually improve by themselves." Also, "all are helped by a cheerful, optimistic, encouraging attitude on the part of the staff." A third therapeutic point that Dr. Bird stressed is the fact that abnormal mental conditions respond well to activity. In his words, "getting patients out of bed early does more than prevent [*Continued on page* 88]

THE SURGICAL NURSE



Today's surgical nursing is professional nursing in its truest sense for it centers on the areas where professional nursing is needed. Operating room nursing demonstrates perhaps more vividly than any other branch what are the unique and invaluable qualities of professional nursing that make it essential to every health program. It demonstrates that good nursing is more than the well-coordinated performance of manual tasks, but rather the product of a disciplined education that develops distinctive sensibilities as well as skills. It establishes the fact that the patient is an entity who "belongs" to no one nurse or to no one branch of nursing, but whose needs must be met by teams of workers. Operating room nursing calls for a well-organized plan of work, sensitiveness to situations, and the ability to anticipate, cooperate, and to keep on learning. These qualities are basic to good nursing whenever and wherever it occurs.

In order to recapture the color and be brought up to date on today's surgical scene, I had myself invited to the Chicago Wesley Memorial Hospital. Through the understanding of the director of nursing, I was able to take my many questions to the surgical and operating units directly. The O.R. supervisor was off duty for the day, but her assistant, Betty Williams, supervisor and clinical instructor of O.R. nursing, was most cooperative in helping me to learn of this new age of surgical nursing.

"Never do I visit this highly animate hospital area without a profound sense of the great changes that have come upon us," I told Miss Williams.

"But the basic requirements re-

by Janet M. Geister

main the same," said Miss Williams, "there must be a 'scrub' nurse and a circulating nurse for every operation, one of whom should be a graduate nurse—thereby assuring each student graduate supervision during her 'on-the-job' experience. The basic need for surgical asepsis, of course, remains unchanged. And the need to anticipate is still paramount—to know what will be needed, and when, and to have it there. The head nurse acts as coordinator to see that all of these needs are met."

The *ability to anticipate* is essential to all professional nursing—it is at its very roots. The public health nurse knows it is more productive to prevent disease than to treat it. The school nurse with her immunization program, the industrial nurse who scrupulously attends to small cuts, the hospital nurse who reports vague symptoms—all acknowledge the fact that anticipating trouble is a good way of preventing it. One of my young friends narrowly escaped death following a tonsillectomy because an aide assured his mother again and again that "they all bleed after that operation." That aide had not known what to anticipate.

"The basic principles may be the same," I commented to Miss Williams, "but certainly you have to know much more than I did long ago. In my earlier days, senior students, next to the surgeon and anesthetist, were the 'whole works' in the operating room. In my smaller hospital we mopped the floors before and after surgery, packed supplies, ran the sterilizers, fought with the engineer for steam, set up instrument tables and sponge basins, and, of course, scrubbed to handle instruments. Often the surgeon worked alone, so we also acted as his first assistants. We never saw brain surgery except in accidents—and in those days of sane driving, head accidents were fairly rare. Heart surgery wasn't even dreamed of, and gall bladder excision was highly daring. Our range of surgery was fairly limited, but yours apparently runs into infinity. How do you keep abreast?"

Her reply was what I'd hoped for.

"Once a month, as part of the in-service education program, the operating room nurses meet to discuss problems and procedures. When a surgeon initiates something new we ask him to explain it to the nursing staff, and our doctors are most willing to do so. For instance, when mitral commissurotomies were started here, the surgeon used illustrated charts to explain the purposes, procedures, and the instruments of this surgery." Here is a point of significance for all nurses. There is no area

of modern nursing that doesn't need continuous, well-organized, and authoritative programs for keeping abreast. Knowing *how* to do procedures is a part of nursing, but knowing the *why* of the procedures is essential to *professional* nursing.

We talked of the interdependence within the operating unit. Anyone who has ever worked in an operating room knows that everybody in the room centers his interest on one thing—the patient on the table. Only one part of him may be viewed, but beneath the drape sheet is a whole person—a complex emotional, spiritual, and physical being whose restoration depends, not on the act of one person alone, but on the smooth coordination of all who channel their combined judgment and skill through the sensitive hands of the surgeon.

However, in spite of this knowledge, modern patient care has a tendency to focus attention on the "exposed" part of the patient—his broken bones or his affected organ. And modern pressures on hospital nurses have tended to accentuate this de-humanization process. Yet it is the nurse more than anyone who can keep humanness in patient care.

I spoke of this failing to Miss Williams and commented, "The operation is the beginning link in the chain of the surgical patient's care. Then you turn him over to the nurses on the surgical floors who too must be posted on the surgeon's plans and procedures." "Oh, no," she quickly interposed. "The chain does not begin in the operating room, but in the pre-operative period. A good deal of the pace and completeness of recovery depends upon the patient's preparation." I asked if that meant the vitamins and fluids that had been poured into me on several such occasions. "That's part of it," she replied, "but just as important is preparation of the patient's mind and spirit. Before surgery, he must understand *his* part in the recovery program. The nurses who care for him before he comes to surgery do that."

Adrienne Jedlicka, clinical instructor of surgical nursing, with whom I later had a talk, elaborated on this point. "Good recovery depends, along with other factors, upon the patient's working with you," said she, "and that begins with the confidence the nurses establish before surgery—not only in him but in his family or whoever brings him in. If the patient knows what he can expect from us and what we [*Continued on page* 91]

R.N. PANEL on O.R. NURSES

A. Clarke: Miss Hall, as founder and president of the Association of Operating Room Nurses of New York, would you tell us something about the history and background of your association? How did it originate? As I understand it, you have been a motivating force in organizing the AORN.

E. Hall: My chief interest in nursing has always been surgery. I specialized in operating room nursing and taught this subject at the Polyclinic Medical School and Hospital in New York City. There's a six months' postgraduate course there for O.R. nurses which attracted nurses from this country and from many foreign countries as well. It was at these classes that the seed of this organization was planted. From the questions asked by the students and the expressions of opinions as to what was being done in their hospitals, it seemed to me that we should get together all these fine ideas and do something about them. At the time, I thought of the organization as a small club.

Origin of AORN

A. Clarke: Then you were more interested in establishing a forum where nurses could pool their ideas?

E. Hall: Yes, a service program, in particular, where we could discuss our own problems, and especially the development of good technique in the operating room.

A. Clarke: You had no inkling at the time that your idea would spread?

E. Hall: No, in January of 1949, I took the first step by calling together a group of operating room supervisors from leading hospitals in New York City for a meeting to discuss the possibility of forming a club. About nine nurses attended that first

Photo: Eugene Taylor

"R.N." panel participants: left to right, Edith Dee Hall, Chairman, National Conference Planning Committee of AORN; Mary E. Kreitz, O.R. supervisor, Kaiser Foundation Hospital, Los Angeles, Calif.; Captain Margaret J. Whitton, ANC, assistant O.R. supervisor, U.S. Army Hospital, Fort Leonard Wood, Mo.; Rose Tashjian, O.R. supervisor, Peter Bent Brigham Hospital, Boston, Mass.; Mrs. Doris Walk, O.R. supervisor, St. Louis City Hospital, St. Louis, Mo.

meeting. They expressed considerable interest in the idea of coming together to combine their efforts, pool their knowledge, and work out some of their problems.

At their suggestion, a second meeting was called with representation from approximately fifty hospitals by either the O.R. supervisor or her assistant. This actually was the first meeting of the AORN, held in February 1949.

A. Clarke: Was all this activity confined to New York City?

E. Hall: Yes, but soon there were groups in other states, and later I found there had been two independent groups working and thinking along the same lines as we were.

A. Clarke: How many units are organized as part of the AORN now?

E. Hall: Between 70 and 75.

A National Organization?

A. Clarke: As I understand it, yours is not a national association?

E. Hall: That's right. Even though our group is called an association, it is actually a collection of local units which meet nationally as a conference group.

We have a National Conference Planning Committee which was set up at this Conference in St. Louis.

A. Clarke: Do you have a national constitution and bylaws?

E. Hall: We don't, but each group has a constitution and bylaws, and I believe most of them were patterned after the bylaws of the New York group.

A. Clarke: What is your ratio of delegates to membership?

E. Hall: One to every 50, or fraction thereof. We have approximately 80 delegates here.

A. Clarke: Is there any idea at present of a national organization?

E. Hall: Well, we're biding our time waiting for further study by our individual local units and by the American Nurses Association.

A. Clarke: Have you had any help in organizing your units from the ANA or the League?

E. Hall: Yes, and this varies with the different groups. In the very beginning, in New York City, we discussed our plans with the ANA on the district level, and we also presented them to a board meeting of the League. At that time we were advised by the League that our place was with the ANA. In due time we became affiliated as a special committee under the ANA on the district level. We have found this affiliation most satisfactory. I believe there are three groups in the United States which have already reached section status with the ANA on the state level.

A. Clarke: May I ask how is the AORN supported financially?

E. Hall: We have no national dues. Individual groups are entirely self-supporting with the exception of the groups which have reached section status in their state. Our National Conferences, and this is the second, are financed by the registration fee and by money received from the sale of exhibit space. Although much has been said to the contrary, we are not sponsored or supported by any commercial organization or company. I think I can say without hesitation that we do have the good will and cooperation of every surgical supply company that is familiar with the activities of the AORN.

A. Clarke: Do you think, in looking ahead, that if the ANA should provide an O.R. section, it would take the place of the AORN?

EMERGENCY

E. Hall: I can't answer that at present, or should I say, no comment. We still must wait to see what develops within the states.

A. Clarke: If I may digress from organization for a minute, I know you are not in O.R. nursing now, but

when you were did you use surgical technicians in your hospital?

E. Hall: Not by that title, although we did have auxiliary help in the O.R. All circulators and instrumentiers were registered professional nurses. I do feel that there is a need for trained surgical technical aides but never, in any sense of the word, to replace professional nurses. I am speaking of civilian hospitals only.

A. Clarke: Could you hazard a guess as to what will happen in the operating scene if more basic courses drop experience of the student nurse in the operating room?

Prognostically Speaking

E. Hall: My guess is that a sad state of affairs will develop. We're in hopes that the pendulum will swing back and that more attention will be given to the surgical program, both from the standpoint of what the student nurse needs and what the graduate nurse needs in the way of advanced preparation in the surgical specialty.

A. Clarke: Have you noticed at all that there is a decreasing number of courses being offered for the O.R. nurse?

E. Hall: Yes. And this is of considerable concern to those of us in this specialty. I believe the courses are not only decreasing but that they have not been properly evaluated for a long time. Besides the institutes and the workshops, which are invaluable for experienced nurses, I believe we need more adequate programs to prepare the inexperienced nurse who wishes to become a specialist in O.R. nursing.

A. Clarke: Wouldn't such accreditation be one of the functions of the National League for Nursing?

E. Hall: Yes, that is my understanding.

A. Clarke: Is there any other body that could do such accreditation, such as the American College of Surgeons?

E. Hall: Personally, I believe it should be done only by a nursing group.

A. Clarke: Thank you so much, Miss Hall. I realize that time is of the essence, and that you're extremely busy at this conference. I appreciate your participating on the panel. If the rest of the panel members are ready, shall we start the discussion of the problems the operating room nurse encounters on the job?

R. Tashjian: We're ready.

A. Clarke: Is this the first national conference of the AORN that you have attended, Miss Tashjian?

R. Tashjian: No. I also attended the first national conference held in New York City in 1954.

D. Walk: It was a fine conference and very successful. We had 1,771 nurses there.

A. Clarke: How many units of the AORN do you have in St. Louis, Mrs. Walk?

Local Development

D. Walk: We have only one unit in St. Louis. It has a membership of over one hundred at the present time. We had approximately 25 members to begin with, and did we have a struggle to start the organization! We had opposition because people did not understand its pur-

pose. Since then we have grown quite rapidly, and I think most of it has been due to that first national conference.

M. Kreitz: Our local unit in Los Angeles formed in 1953. We had about 25 members to begin with. We have since grown to, I believe, 75 members.

A. Clarke: Captain Whitton, I understand you were in Korea last year when the national conference was held in New York.

M. Whitton: That's right.

A. Clarke: When did you join this group?

M. Whitton: The first day I came to this meeting.

A. Clarke: As an army operating room nurse, do you think from what you have seen and heard at this conference that this group will help you in your particular work?

M. Whitton: I definitely think it will.

A. Clarke: What are the particular problems that operating room supervisors, or actually any of the nurses in the operating room, find that they need to consult with each other on?

D. Walk: One of the major problems that's existed over the years is sterilization, especially chemical sterilization. We did not know exactly what some of the solutions did although we had help from sales representatives; and, also, we didn't know the lengths of time for sterilization—especially chemical.

A. Clarke: Miss Tashjian, do you find you have a similar problem?

R. Tashjian: I don't have that problem. We are fortunate to have one of the leading sterilization experts on our surgical staff at Peter Bent Brigham.

A. Clarke: Oh! Dr. Carl Walter is at your hospital. He *is* a specialist in his field.

R. Tashjian: He is one of the outstanding men in the field of asepsis and operating room technique.

A. Clarke: If you're so fortunate to have a specialist in your hospital, what are the other types of problems that you might want discussed in a group such as this?

R. Tashjian: Well, I think that the problem that exists in our hospital is that of graduate nurse education, and how to keep the graduate nurse's interest and have her feel that she is part of a team.

A. Clarke: How do you interest graduate nurses in O.R. nursing?

R. Tashjian: I am at a university hospital where the nurses are very interested in the operating room.

A. Clarke: Do you have a certain percentage of new graduates who want to come into surgery?

R. Tashjian: Yes, there always are. Last year, out of a group of 35 we had four newly graduated nurses who joined our staff.

A. Clarke: At your particular hospital, what is the time that students spend in the operating room, four weeks, six weeks, eight weeks?

Student Nurse Experience

R. Tashjian: The student program lasts for eight weeks. A clinical instructor in the operating room devotes her entire time to teaching the student nurses.

A. Clarke: Are there any plans to reduce the number of weeks' experience that the student now gets in the operating room?

R. Tashjian: None whatsoever that I know of.

A. Clarke: How about some of the other hospitals? Do you panel members know of plans in your individual hospitals to change the length of time?

D. Walk: Not at St. Louis City Hospital, although there is quite a bit of talk concerning it. Presently, our course lasts nine weeks.

A. Clarke: Miss Kreitz, do you have students at Kaiser?

M. Kreitz: No, we do not. I believe that in the Los Angeles area schools have not changed the number of weeks of student experience.

A. Clarke: Have you thought of, or discussed, at any of these O.R. meetings, the new trend in nursing education of eliminating operating room experience completely and having the student exposed to theory only?

M. Kreitz: We did discuss that at a recent meeting, and it was the opinion of the group that the present policy should be continued. We feel that the best reasons for it are that the students become familiar with aseptic techniques as part of the total surgical program, and also that the elimination of this experience would tend to decrease the number of students who would be interested in the O.R. as graduates.

A. Clarke: Mrs. Walk, do you find that it is difficult now to interest graduates in operating room duty?

D. Walk: It isn't so much interesting them, it is that we have a hard time trying to keep them settled down in one spot for very long. Last year we had a total of six nurses from the graduating class, four of whom married and left.

A. Clarke: Do you think that operating room nursing is any more difficult or any more tiring on an individual than general duty nursing?

M. Whitton: Yes, I believe it is. Because there is more mental strain. You not only have to think of the patient but also the O.R. personnel whom you are working with.

R. Tashjian: Fatigue that is created after an eight-hour day in an operating room not only consists of physical fatigue but also mental fatigue because most of the time the O.R. staff is working under an emotional strain.

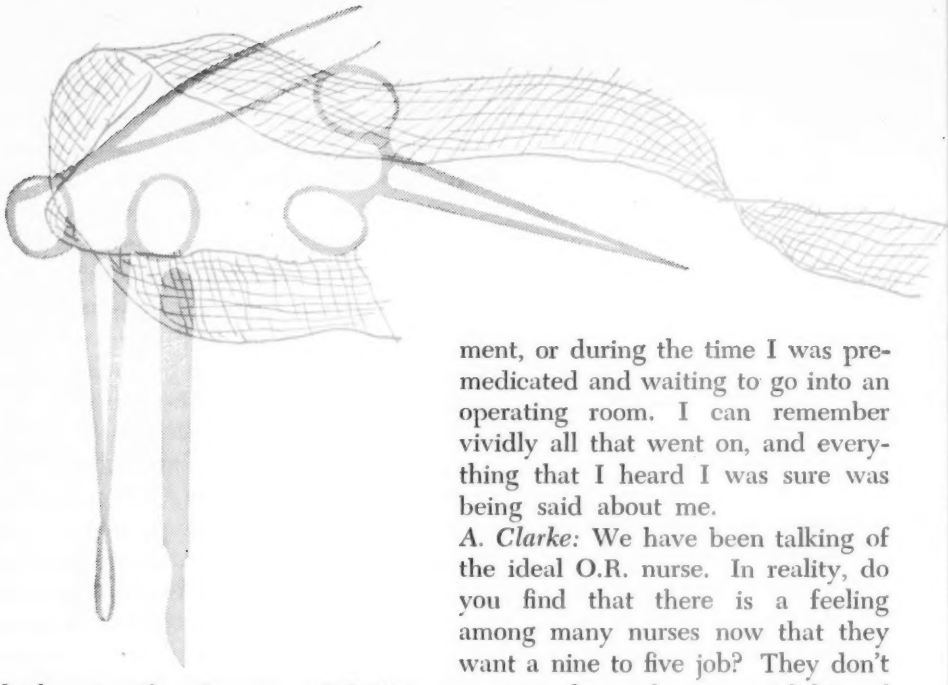
The Ideal O.R. Nurse

A. Clarke: If you were able to order a tailor-made nurse for the operating room, what would be your requirements or specifications?

M. Whitton: One who is able to stand up and take it.

R. Tashjian: One who has a great deal of interest in the job and is willing to work with others on a cooperative basis. I think interest is of the essence. I think everything else follows in line.

D. Walk: I have found that operating room personnel, as a whole, usually have quite positive personalities. I think they are different from other nurses in that they are aggressive people. And by aggressive I



don't mean the obnoxious definition of aggressive. I think most of them are young and are willing to work long, hard hours. You will very rarely have a nurse in the operating room who is not sincerely interested in her work.

M. Kreitz: I think besides having interest, the O.R. nurse must also be adept.

A. Clarke: You mean adept in manual dexterity or adept in changeability of personality or temperament?

M. Kreitz: Both.

A. Clarke: Then you mean she must be adept and also have adaptability?

M. Kreitz: Yes. I'd also like her to be kind and interested in patients. Many O.R. nurses tend to forget that the patient is an individual. From my own personal experience, I have found that I was never more sensitive in my life than at the moment, or during the time I was premedicated and waiting to go into an operating room. I can remember vividly all that went on, and everything that I heard I was sure was being said about me.

A. Clarke: We have been talking of the ideal O.R. nurse. In reality, do you find that there is a feeling among many nurses now that they want a nine to five job? They don't want to have the responsibility of working overtime. They don't want to think about taking O.R. call, for instance.

M. Kreitz: Yes. I can say from experience that this feeling does exist. However, I can't quite come to believe that it is connected just with nursing. I think the whole attitude of the world today, or at least the people in this country, is that the world owes me a living.

M. Whitton: That's why we should choose one who can stand up and take it.

A. Clarke: Aren't we sort of narrowing ourselves down in the number of people we are going to interest in the operating room then?

D. Walk: We were all trained at one time or another that whatever was for the interest of the patient was not too menial for the nurse. Stu-

dents today don't seem to have that attitude. For instance, they resent pushing stretchers, or mopping up floors.

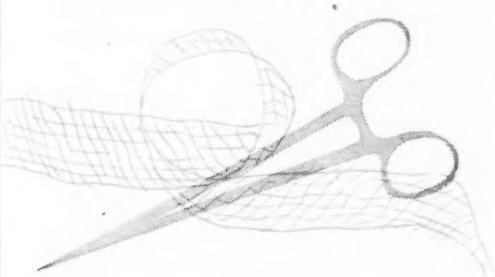
A. Clarke: Doris, for heaven's sake, **R.N.** readers will think you're at least sixty.

D. Walk: You can testify that I have a few more years to go yet. What I mean is that you measure nursing levels on a professional plane, that's true, but I think that the emphasis upon degrees has gone just a little too far. Everybody wants to be a teacher, nobody wants to do the work. That is the general impression.

R. Tashjian: I think that the impression has been interpreted incorrectly. I think that nursing has been too narrow for too many years. The reason why education is now being stressed is because nurses feel a need to broaden themselves, to be well-rounded individuals, not just technically trained.

A. Clark: I asked Miss Hall earlier what she thought was the place of the surgical technician. What are your opinions on it?

D. Walk: Now more than ever, with the emphasis on preparing the nurse for higher-level duties, there is a place for the practical nurse or the technician in the operating room.



However, the question is whether it is worth the time and effort. I set up a course about three or four years ago for training practical nurses. At the beginning it was very successful. I had four students who ranged from their late twenties up to fifty. It was quite a difficult task, but I felt in the long run it would probably solve some of our problems. It did temporarily. But since that time, I have exactly one practical nurse left. One dropped out because she felt that scrubbing was too hard at her age. Another married, and the other left to take a job elsewhere.

M. Whitton: Do you train only female personnel in your program?

The Surgical Technician

D. Walk: Well, at this point they're the ones who've applied for the course. I would think that males would probably stand up under the strain much better than females.

R. Tashjian: I think the problem of technical aides leaving is not only a problem with them, but also the graduate operating room nurses. But with technical aides, you have to be very careful in selecting them.

D. Walk: I thought when I made my choice that it was a good choice; we screened the candidates very carefully. They knew nothing of basic anatomy, they knew nothing of surgical instruments, but they were extremely interested. Then we found that most graduate nurses do resent the technicians because they feel they are replacing them. Most operating room nurses like to scrub

a great deal and technicians may take away this job satisfaction.

M. Whitton: Speaking on the basis of my army experience, I would judge that if you hired or trained some male personnel you would do a lot better.

M. Kreitz: I'm in a different situation than yours, Captain Whitton, but I have employed male technicians too. The problem that I encountered in a private hospital was one of friction between nursing and the male technician personnel. The technician always felt that the R.N.'s were trying to push things off on him that they didn't want to do themselves. And he couldn't meet them on their own professional level. The R.N.'s felt that the technician only wanted to scrub and to do nothing else. We all recognize the fact that in spite of having auxiliary help in the operating room there are still times when everyone has to be called upon to fold linen, perhaps do up packs, and wash instruments. Those are the things I had trouble getting him to do. It was a traumatic experience for everyone concerned, plus the fact that once he was trained, he felt that he was underpaid and pretty specialized.

D. Walk: We have the same problem. At our hospital we still do not have the title of technician or practical nurse. According to civil service, technicians are on the attendant level, a grade which they resent. So the overall picture is bad because they feel they are as good as the professional staff, and should be compensated accordingly.

A. Clarke: Well, don't you think it is a natural thing, the better a person gets in a certain field, the more recognition he wants? We are creating a problem bringing technicians into the O.R., the same way we created a problem bringing practical nurses into hospital wards. Prestige-wise, we have no place for them to go. We haven't provided the means for them to improve their status one way or the other except salary-wise. If the R.N.'s salary has such a low basic minimum and the technician's salary is so close it causes resentment, what is the solution?

M. Whitton: To raise the salary of the R.N.

A. Clarke: Very well said. Captain Whitton, you say that you don't have a problem in the army when you use corpsmen for scrub technicians. Why?

M. Whitton: Well, we have our problems. Don't ever get it into your head that we don't. But, the corpsmen come in on a trial basis. They know this when they come in.

Army Corpsmen

A. Clarke: How is the surgical corpsman compensated?

M. Whitton: We hope to goodness that in time he gets another stripe, which is very hard, and with it an increase in pay. But these men, from my observations, are so interested in their work that there is not too much said about an increase or another stripe.

M. Kreitz: Could I say, Captain Whitton, that you don't have a problem in the army because the

advancement of corpsmen doesn't present a threat to the nursing service that the technicians do to the R.N. in private hospitals. In the army, the nurse's rank is very well established.

A. Clarke: Captain Whitton, do you find, as I found in my army experience in training corpsmen, when they perfected their technique, you had to watch them twice as carefully as you did before? They have a tendency to identify themselves with the surgeons.

M. Whitton: That's very true. When I'm on call, I inform the corpsmen that I am to be called regardless of what comes in. We have some excellent technicians who at times will say to themselves—we won't call Captain Whitton tonight, we'll just take care of it.

R. Tashjian: I feel that there is a great need for the surgical technician if a hospital runs into a personnel shortage and cannot get professional help in the operating room. Actually, though, I don't think surgical technicians will ever replace operating room nurses. The place of the technician has been misconstrued. It has aroused unnecessary fear in a lot of operating room nurses.

A. Clarke: But don't you think, possibly, that this fear is a combination of two things rather than one? On the one hand, we're introducing technicians into the field of the operating room to do the actual scrubbing, and on the other, we're reducing the student nurse's program, in some instances, eliminating her whole operating room experience.

R. Tashjian: Well, it's apt to be a combination of the two things. I don't think that we can say that technicians are going to replace us because, personally, I don't think they ever will.

A. Clarke: From your own personal experiences, if you had not had time in the operating room as students, do you think any of you would have chosen operating room nursing as a specialty after you graduated?

Educational Trauma

R. Tashjian: That's very difficult to answer. I think, in some instances, nurses who have the time and money would continue on to do postgraduate work in surgery. And the idea of the excitement and glamor of the O.R. in itself might arouse interest. But, granted, I don't agree with the thinking that experiences in the O.R. should be completely eliminated. I do feel that there is room for investigation. Can students have the same amount of teaching and absorb the same content in a six-week period as they can in an eight-week period?

A. Clarke: Captain Whitton, what has been your experience in Korea of getting available nurses with operating room background?

M. Whitton: Well, my experience in Korea or any combat area that I have been in, in fact, has convinced me that nurses definitely need O.R. experience. I had little operating room experience other than what I had in training. When I was assigned to an operating room in a field hospital, [*Continued on page* 92]

Maintenance

[*Continued from page* 41]

profound shock, and systemic collapse that may prove fatal. The management of the latter state includes oxygen, respiratory and cardiac stimulants, and I.V. Adrenalin 1:1000.

Still another reaction results from speed of administration. When fluids are given too rapidly, the patient may suffer from cardiopulmonary embarrassment with dyspnea, cough, elevation in pulse and blood pressure, cyanosis, and apprehension. Oxygen, morphine, and reduction of the blood volume by rotating tourniquets or phlebotomy are measures which may be used in treating this untoward reaction.

If there is any evidence of a reaction to blood or other I.V. fluids, the nurse should:

- Shut off the fluid or blood immediately.
- Leave the needle in the vein for administration of other medication.
- Call the physician.
- Give oxygen.
- Raise the head of the bed so that the patient is in a semi-sitting position if difficulty in breathing occurs.

Despite the fact that the intravenous route appears to be preferred by doctors, other methods of introducing parenteral fluids are used, and in fact, must be used in certain cases.

Hypodermoclysis, or the administration of fluids into the subcutaneous space, has the advantage of being an easily performed technique which allows for slow absorption. This method is often quite uncomfortable and the absorption rate cannot be controlled. Furthermore, absorption is delayed with isotonic non-electrolyte solutions and hypertonic solutions. With hyaluronidase, however, an enzyme which hydrolyzes the "cement substance" of connective tissue, it is possible to provide more rapid dispersal and absorption of solutions, drugs, anesthetics, and plasma by the subcutaneous route. Fluids administered into the peritoneal cavity by intraperitoneal infusion behave similarly to those administered by hypodermoclysis.

The administration of fluid into the stomach by a nasogastric tube is indicated when there is a normal gastro-intestinal tract, but when an adequate intake by the oral route is not possible. Nasogastric tube feeding might be resorted to, for example, in the management of patients with nervous system lesions and those who have had radical head and neck surgery. A wide variety of substances, including calories and protein, may be given by a constant gravity drip, by intermittent injection, or by use of a force pump. Small polyethylene tubes are used to convey the fluid. Solutions may also be introduced through tubes inserted directly into the stomach or jejunum.

Proctoclysis, the administration of fluid by rectum, was frequently used in the past, but is rarely used today. It is not an efficient way of providing fluids and is often annoying to the patient.

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RN-55

Solutions

[*Continued from page* 51]

come depleted during dehydration is potassium. Until just a few years ago, potassium imbalance was rarely recognized or treated, as the symptoms are often neither very specific nor too dramatic. Recent studies have shown, however, that potassium deficiency is a condition much more prevalent than had been previously suspected and dangerous enough to produce serious disturbances of function and even death.

While small losses of potassium are not serious and may be manifested only by loss of appetite and nausea, lower cellular levels of potassium in the skeletal and cardiac muscles may lead to respiratory difficulty and finally to death due to heart failure. Because potassium depletion brought about during the stress of surgery may markedly affect the patient's postoperative progress, many surgical services now include the ion routinely in parenteral fluid therapy.

Although such salt injections may be lifesaving, the intravenous administration of potassium is not without danger, especially in patients suffering from kidney disease. Injections should be made slowly and in dilute solution, as too rapid a rate of infusion of concentrated solutions can cause potassium poisoning if the kidney cannot excrete the excess. Therefore, it has been suggested that intensive potassium administration should not be performed without laboratory facilities capable of checking on the amount of potassium in the plasma at all times.

Oddly enough, too high a piling up of potassium causes symptoms somewhat similar to those seen when there is too little. In both cases, changes occur in the rhythm of the heartbeat, followed finally by cardiac arrest. Because of the close correlation between plasma-potassium levels and certain changes seen in electrocardiographic tracings, it is imperative that both these indices be checked frequently.

While these precautions may require elaborate equipment and techniques, the alert nurse can also be of help by watching for such danger signs as lessened urinary output,

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numbness, tingling, weakness of the extremities, and pulse irregularities.

Another bodily balance that may be disturbed during states of dehydration is that between acid and base. In health, the hydrogen-ion concentration of the body fluids stays slightly on the alkaline side, despite the constant production of acid end-products from foods as they are being metabolized. Loss of body base due to dehydration results in an accumulation of excess acid ions in the blood stream. Solutions of sodium bicarbonate and of sodium lactate are available for furnishing the alkali needed to neutralize this acid.

However, other ionic abnormalities may also have to be corrected simultaneously by giving potassium, calcium, chloride, and water in proper quantities. Likewise, in alkalosis due to depletion of chloride, which occurs when excessive amounts of gastric juice are lost through vomiting, the acidifying salt, ammonium chloride, may be administered parenterally to supply the deficient ion. Here, too, though, it may be necessary to give such other important substances as potassium and sodium at the same time to restore normal equilibrium.

While keeping the composition and amounts of body fluid in balance are usually enough to maintain normal neutrality, other measures may also be required sometimes. If, for example, the body begins to burn up its own fat and protein due to depletion of its carbohydrate stores, acidosis may result

rather readily from the production of excessive amounts of ketone bodies and acid metabolites. To prevent this and to save the body's own protein from destruction, carbohydrate, a common calorie source, may have to be administered as a means of meeting the body's energy needs. When the patient cannot take food by mouth, the carbohydrate may have to be fed intravenously.

Since the more complex carbohydrates found in foodstuffs cannot be given by vein, simple sugars such as glucose, fructose, and invert sugar are often administered. Unfortunately, these alone cannot supply enough calories to meet the daily dietary demand, particularly in patients who have already lost weight and in those in whom impaired cardiac function reduces the amount of fluid that can be safely injected. At best, no more than three or four quarts of fluid can be infused in a twenty-four hour period. This means that with a 5 per cent glucose solution, one quart of which supplies but 200 calories, only something less than half the daily energy requirement can be furnished by injection of sugar solutions.

More highly concentrated glucose solutions are also available, but these have the disadvantages of being irritating to the veins and causing diuresis. The latter action not only increases the chances of the glucose itself being excreted before it can be utilized, but may even lead to further disturbance in the distribution and composition of body fluids. Recent investigations indicate that

fructose may be more efficiently metabolized than glucose, and that high concentrations of fructose may be less disturbing to fluid balance than are glucose solutions of equal strength.

Other substances that supply energy in amounts even greater than those furnished by carbohydrate are fat and alcohol. The latter, in dilute dextrose solution, serves not only to make available additional calories, but also is a mild sedative and analgesic. Of course, the rate of administration must be controlled to prevent the patient from becoming inebriated, but careful control of intravenous infusions is a necessary precaution in any case.

Although fats offer more energy than any other source, their insolubility has made parenteral administration a problem. Recently, however, fats in emulsion form have been introduced for oral and intravenous use in severely emaciated or undernourished patients who need concentrated calories. While palatable oral emulsions are already on the market, problems of stability and safety still remain to be solved before the parenteral preparations can be made generally available for patients who cannot take fats orally.

For such patients and others who have lost considerable tissue nitrogen through trauma, burns, fever, and a number of other conditions, protein, too, must be given parenterally to restore nitrogen balance. This vital element may be supplied either in the form of synthetic amino

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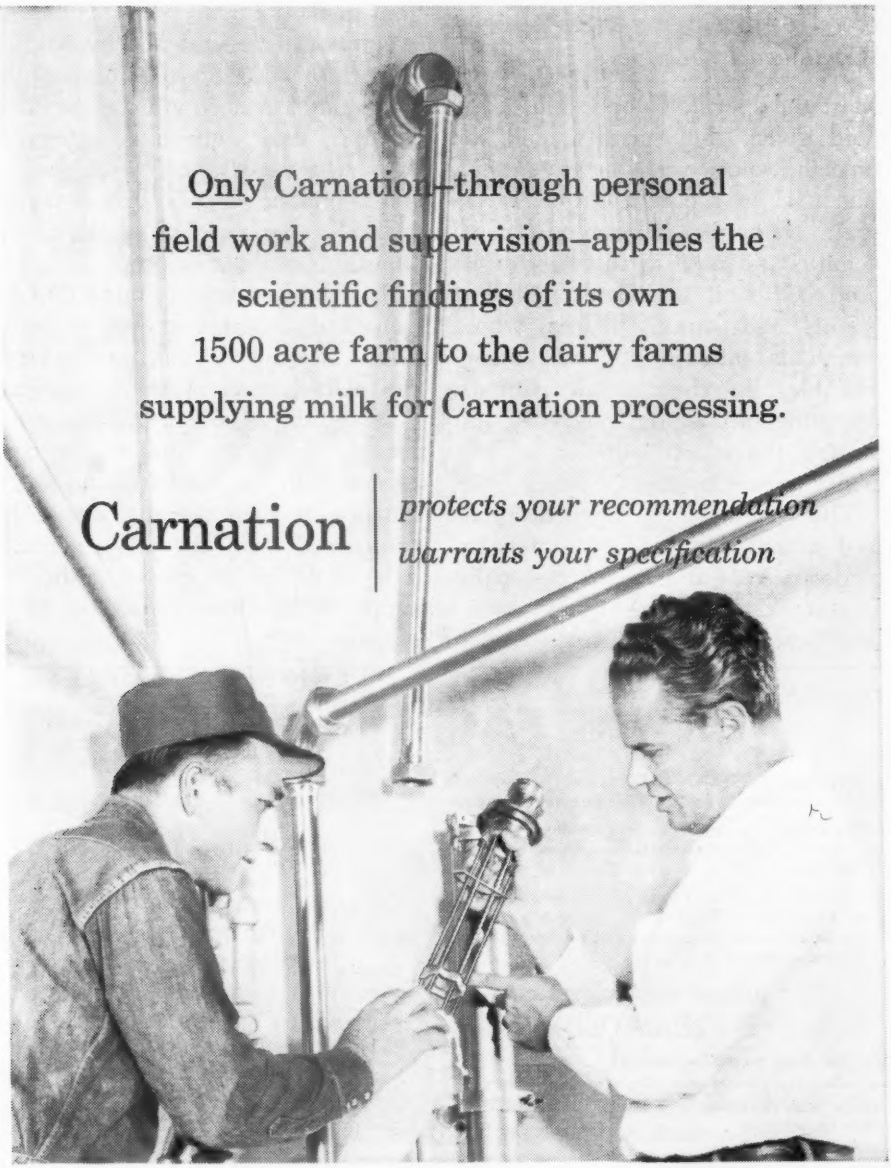
acids or as less expensive protein hydrolysates—mixtures of essential amino acids prepared artificially by the partial digestion of casein, fibrin, and other sources of protein.

Because of the many undesirable allergic and pyrogenic reactions that may occur, parenteral protein alimentation is never an adequate substitute for good, nourishing food by mouth. It may, however, be lifesaving in certain severe illnesses and especially after surgical operations on the gastro-intestinal tract. Best results are obtained when maximum quantities of calories are supplied simultaneously, as the usefulness of the amino acids is limited by their being, in part, burned for energy instead of becoming building blocks in the synthesis of proteins.

Concentrated solutions of human serum albumin and plasma are sometimes given by vein combined with carbohydrate to supplement the diet. More often, however, these blood products are used, not for nutrition, but to restore plasma volume to normal in treating shock when red cells of whole blood are not required.

Also used to keep blood pressure up in emergencies are the "plasma-expanders"—chemical compounds of high molecular weight that act like plasma proteins by drawing fluid from the tissues into the blood stream and keeping it there to maintain the blood volume. While none of the plasma extenders developed thus far has all the useful properties of plasma and of blood, some, such as dextran, gelatin, and polyvinylpyrrolidone, have certain advantages over the natural products, including freedom from the infections sometimes transmitted by blood and its products.

Many other substances, from vitamin supplements to vasopressor drugs, may also be injected directly into the blood stream. Although I.V. therapy is expensive and sometimes dangerous, the use of intravenous fluids appears to be on the increase. Since administration of fluids and medication by this route is usually the responsibility of the nurse, she should prepare herself to perform this part of her job with a skill that is based upon a thorough understanding of the principles of parenteral therapy.



...may we have your support for

I.V. Therapy

[*Continued from page* 43]

chart the specific composition of the fluid given, the quantity, and the time the solution was begun and finished. If an accurate output is desired, they must also see that all vomitus and urine is carefully measured. Often it is difficult to follow infants and small children whose output is intermittent and uncontrollable. In these small patients, diapering at hourly intervals and making the simple notation of wet or dry is most useful.

The weight of the small hospitalized patient should be accurately recorded at least once, and occasionally as many as three times daily. Accurate beam-type baby scales suffice for small infants; older children's weights can be obtained by holding the child in the arms during the weighing. An accurate weight chart is the most effective safeguard against overhydration, which is the most common complication of parenteral therapy in children hospitalized in adult hospitals.

It should be kept in mind that infants and children, as well as many adults, are not able to participate in the management of their own parenteral fluid therapy. All the more reason, then, that individuals concerned with the initiation and maintenance of such therapy should be acquainted with the problems and dangers of this important method of supplying the fluid requirements of patients.

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A Surgical Miracle

[*Continued from page* 57]

entirely new surroundings, among other patients, with opportunity for diversion, self-centered ideas and worries gradually disappeared.

During the rehabilitation period, physiotherapy was begun to enable the patient to regain strength and muscle tone more rapidly. The nurses supervised daily bed exercises. Strength was also gained by a change in diet. After four weeks, he was started on oral fluids, progressing to a general diet in six weeks.

After seven and one-half weeks of hospitalization our patient was discharged from the hospital, ambulatory. The doctors have told him that he will soon be as strong as ever. Alert and smiling, as he walked out of the hospital, no one would have recognized him as the same man who was admitted on a stretcher a little less than two months before.

As one of the private duty nurses for this patient, I was impressed with the teamwork and cooperation from fellow workers and members of allied departments of the hospital. From the time of his admission until his discharge, everyone who came in contact with him showed the utmost care and patience in fulfilling his needs. The challenge, as in all nursing, was great. The physical and emotional strain was sometimes almost overwhelming, but, in my career as a nurse, never have I found an experience so satisfying or one so rewarding.

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Psychological Care

[*Continued from page* 60]

physical regression—it is excellent for the mind, too."

Finally, these patients can often be helped if they can bring their problems into the open. Dr. Bird emphasized that the best way to accomplish this is to encourage the disturbed patient to talk. "If, by sitting down and talking with him, the surgeon or nurse can help the patient to put into actual words his hazy fears, his vague sadness, and his embarrassing anger, he will often feel much better immediately. In fact, if a patient can express his feelings accurately, it is almost impossible for him to become apathetic, depressed, or confused."

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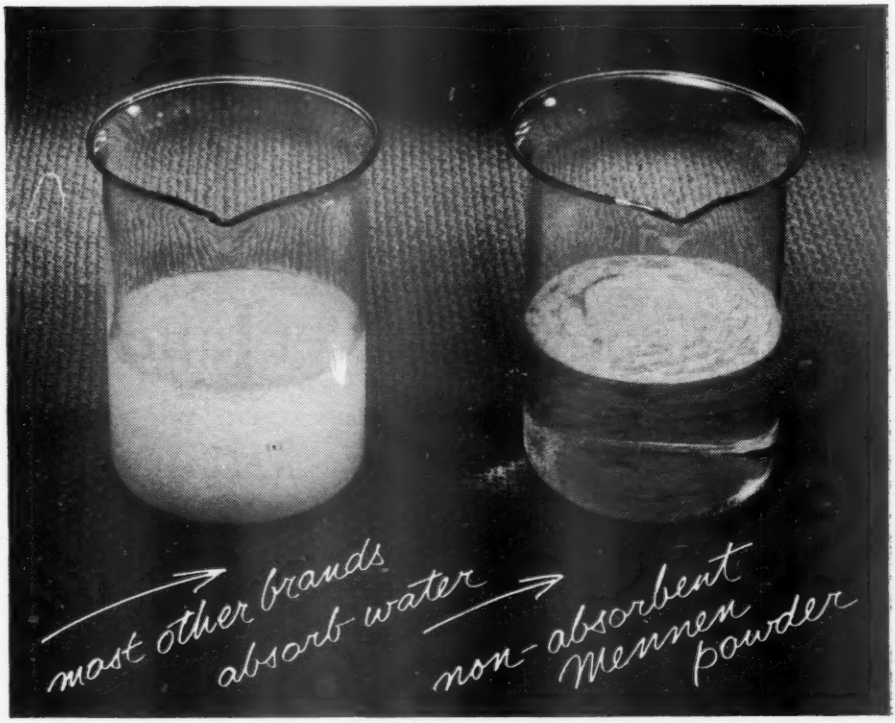

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Surgical Nurse

[*Continued from page* 63]

expect of him, he is ready and eager to cooperate after surgery. For example, take a patient with cataracts. He knows before the operation the importance of not moving his head after surgery. Though later he cannot see, he knows us and, because of his preparation, works with us.

"Our whole effort is to individualize the patient, to teach him, to gain his confidence, and to help him to go for his operation relaxed. Our attitude in these preparations tells the patient in ways much plainer than words that we expect him back. And if we do a good job before surgery, our job afterward is lightened." Again that stress on anticipation.

It seems to me that these surgical nurses, the O.R. and the floor nurse, epitomize in their activities the unique and basic values of professional nursing. Every reasoning person knows there are certain functions in the nursing care of patients that can and should be assigned to helpers. And that is precisely the aim of nursing in every realm today—to lop off extraneous duties and concentrate on those that are professional nursing. But in some areas, especially hospital staff nursing, the lines of demarcation are not as readily discernible as in the O.R. Here the floor mopping, the glove inspecting, and autoclaving jobs are done by others —under nursing supervision.

But there are other hospital areas where persons with less adequate preparation simply cannot function with safety or effectiveness. The nurse who serves the patient directly anywhere has the greatest impact on him. She represents not only the whole nursing profession but the whole institution. It is her attitudes and actions that set the pace of the patient's cooperation, confidence, and peace of mind. It seems to me that in our present shortage of qualified administrative and teaching personnel it is more important than ever that the nurses serving the patient directly be of top quality. It is these nurses whose responsibilities are so acutely broadening, not diminishing.

There are no substitutes for the inherent qualities of professional nursing—nor are there short cuts to them. Some of the advocates of the two-year school put stress on the need for more *numbers*—such reasoning is basically wrong. There are similar shortages of engineers, doctors, scientists. Has anyone even heard a suggestion that their basic courses be cut by a month, let alone by a year?

Years ago I fought a hard battle with a university dean who held that "nurses" with six months' training would do quite all right as public health nurses for rural folk. I held that the closer the nurse was to the patient and his situation the more essential it was that she be *quality*, representing the best, not the least, in nursing. In my old-fashioned way I still hold to that idea, whether the nurse be at the hospital bedside, in the home, or passing instruments over an anesthetized patient in the operating room.

Panel

[*Continued from page* 73]

I would, unfortunately, have been in a pickle if I had had no O.R. experience to draw upon. You can't recall what you've never known.

A. Clarke: What was your reaction to Sister Suzanne's remarks today about the traumatic experience that the student nurse goes through in the traditional operating room affiliation?

M. Kreitz: Well, I think it is a sad but true commentary.

R. Tashjian: I don't feel that it's true today.

A. Clarke: Do you think it's because nurses in teaching positions are learning more about the fundamentals of teaching?

M. Kreitz: May I state, too, that I think our knowledge has increased a great deal due to men like Dr. Walter. We feel more confident. When you are unsure in any situation you are not going to be as kind to the person you are expected to teach.

R. Tashjian: We have gotten away from the teaching process of a rod in hand. We have found that teaching by guidance is a much more acceptable method . . . and more productive.

A. Clarke: I think Miss Kreitz has hit upon something. Most of us, when we are unsure of ourselves, hate to admit it, and are much more likely to be adamant in such a situation, right or wrong.

Shall we now move on to other problems? Could you agree that all

of you have at least one criticism of the anesthesia department? If not, the scene has changed considerably since my days in surgery.

D. Walk: Our R.N.'s complain that they have to pick up after the anesthetists or run to get them supplies when it is uncalled for—that is, when it does not concern the welfare of the patient.

A. Clarke: You all agree to that?

M. Kreitz: This is precisely the problem that bothers us.

M. Whitton: Maybe I'm wrong, but I do instruct my circulating corpsmen that their job is to circulate for the persons who are scrubbed, and they are not to be waiting on the personnel of the anesthesia department.

Interpersonal Relationships

A. Clarke: Why is there this feeling toward the anesthesia department?

R. Tashjian: I don't agree with that at all. I myself instruct all my graduates that when they are in charge of a room, they are not to think just of the instrument table and of the scrub nurse, but they are also to think of the patient. The patient is their first concern, and if anyone — including the anesthetist — needs help, that help is to be given.

M. Kreitz: I think what Mrs. Walk meant was that there really are many little cleaning duties in a room after a room has been used, and before it is used again. Certainly the nurse anesthetist should take care of her own area.

R. Tashjian: As I said before, we do not have problems with our anesthesia department, because of the

fine cooperation between the two different departments.

A. Clarke: Do you have a surgical committee at your hospital?

R. Tashjian: We have a committee that is called by the chief surgeon usually about once a month. On that committee serve the surgical chief, who is the director of the meeting, the director of nurses, the operating room supervisor, the chief anesthesiologist, his associate, and the anesthetists. All personnel problems can be discussed at this meeting.

A. Clarke: Do any of the rest of you have such a committee, or do you iron out the problems between departments by other means?

M. Whitton: Well, in the army we have a meeting approximately every two weeks with the chief of surgery, also the operating room supervisor, the anesthesiologist, and the surgical ward supervisor.

M. Kreitz: We are not fortunate enough to have a surgical committee. We've only been in existence for about two years. We hope to form one, though, but in the meantime, we do have head nurses' meetings and also combined department meetings.

A. Clarke: Do you find that since the nurse anesthetists have their own association where they can talk about these problems in groups, the same way the operating room nurses can, that there is more cooperation and understanding between these two groups?

M. Kreitz: Yes, I think that is so, very definitely.

R. Tashjian: I think the problem of

inter-departmental clashes can be based on the fact that it is personalities that cause friction, not specialties. And when the personality of one department head clashes with another, it's apt to affect the rest of the staff.

A. Clarke: Can I interrupt here just for a second? Do you think, if we can analyze the basic problem of the relationship between the O.R. nurse and the nurse anesthetist, that there may not be somewhere in the background the misunderstanding, for instance, of why is a nurse an anesthetist? Is this a nursing specialty? What is the status position of the nurse anesthetist in relation to the O.R. nurse? Could it not be this fogging of status rather than the surface complaints that accounts for this problem in interpersonal relationships? (Sorry you have to leave us at this time, Miss Tashjian, thank you so very much for your welcome contributions.)

Another question I would like to ask is on the matter of the relationship of the O.R. nurse with the rest of the hospital. More specifically, I want your opinion on why so many nurses—general duty nurses, even directors of nurses, and nursing educators—believe that the operating room nurse is interchangeable with a staff nurse or general duty nurse, and that there should be no difference in their personnel policies?

D. Walk: I think much of the resentment that exists between graduate nurses on the floors and the operating room nurses again arises from misunderstanding. Operating room

nurses seem to belong to their own cliques. It isn't really true. Because of their close association in their work, they do have a common bond which carries over into their social life. It exists in all other fields, too. Now as far as the problem of paying more money for operating room nurses and for on-call time, I think that this is justified. The operating room nurses do, as a general rule, work longer hours than the floor nurses. Operating room nurses are never certain when they will get off duty. Also, most operating room nurses have had added preparation.

Personnel Policies

A. Clarke: But what about the criticism that the O.R. nurse's day is not comparable to the length of the day of the general duty nurse? You usually don't schedule cases after 2:00 P.M., do you?

D. Walk: Our schedules just never seem to end. We no more than finish scheduled cases when emergencies begin. Therefore, you cannot say our schedule stops at 2 o'clock although we do have a 2 o'clock deadline for scheduled procedures. There is very rarely a night that passes without some sort of an emergency. Therefore, we never get off early. If someone is off, it is because they are let off for overtime that is due them.

A. Clarke: At your particular hospital, how do they arrange salaries, overtime payment, and time off for extra work?

D. Walk: We do not compensate in salary for time on call; it is given back. We have a record book in which we keep the exact amount of time spent on duty, and this is given back when convenient. If a nurse has worked the entire night or a great portion of the night she is given the next day off.

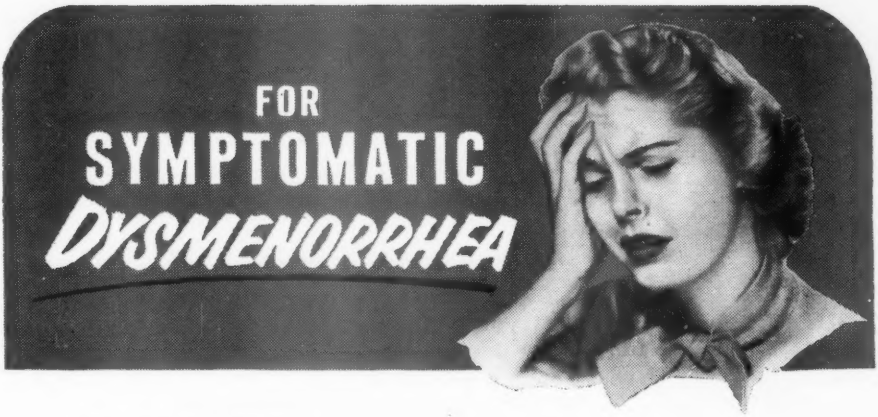
A. Clarke: Do you have any policy of before or after midnight calls?

D. Walk: No, our nurses go on call as soon as the day's schedule is over.

A. Clarke: Now, you say they don't get paid for call? Do they get a higher salary than do the general duty nurses?

D. Walk: No. We are on the same salary scale as the general duty nurses and we are not compensated in any way.

A. Clarke: Miss Kreitz, do you have



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different policies in your area?

M. Kreitz: Yes, we do. On the West Coast the salaries are somewhat higher even for general duty, I believe. Our nurses are paid $10 more than the general duty nurses for their surgical specialty and for that alone. The O.R. nurse must have a year of postgraduate work behind her before she is entitled to the $10 differential. Then we have three shifts in the operating room; we're covered around the clock.

A. Clarke: You don't have any nurses on call?

M. Kreitz: There is just limited call. There's call over the weekend which the day people take themselves. We pay half-time pay for every eight hours of call. That is, if the nurse is on call Sunday for 24 hours, over and above her salary she receives 12 hours of regular pay whether she works or not.

A. Clarke: If she works?

M. Kreitz: If she is called during that time she receives time and a half for each hour, broken down into fifteen minute periods. That is, if it is an hour and three-quarters she's paid an hour and three-quarters at time and a half.

A. Clarke: Does there seem to be a trend on the West Coast of staffing the night shift with a permanent operating room member, rather than depending upon nurses who are on call?

M. Kreitz: I believe there is, but I would have to check further to be sure. I know of a number of hospitals that do keep someone on. We, of course, have quite a full P.M.

shift. Our day shift is 7 to 4:30. Our P.M. nurses come on at 3 o'clock, to tie in with the day people until 11:30, and the night nurse is on from 11:30 to 7:30.

A. Clarke: Do you find that by having a permanent nurse on night duty that there is a better feeling about working in the operating room? Would you think that on-call duty might deter nurses from coming into the operating room?

M. Kreitz: I'm quite sure that is true, and I think that the policies in my particular hospital are quite generous and have resulted in our having very little trouble in recruiting nurses for O.R. duty.

M. Whitton: We have no such problems as these in the army. *You're on call.* Of course, I will say that if we are up during the night after midnight the supervisor tries to let us off. If not for the entire day, for the morning anyway.

D. Walk: Although we have three shifts also (we have two people on each shift—a student and a graduate), we also have an O.R. call nurse. However, we have trouble getting nurses when they know they have to work the rotating shifts and take call too. We have worked on it several times, getting permanent personnel for both evening and night shifts but it is difficult to get someone who will consistently work on these shifts.

A. Clarke: Pay a good salary and nurses will work those undesirable shifts. Is that the answer?

M. Kreitz: I think there are many who will adapt their lives to a good

salary. Now the P.M. nurses, over and above the $10 differential for their surgery specialty, also receive an additional $15 for this shift.

A. Clarke: You pay more for P.M. than you do for the night shift. Why is that? Is it harder to staff the P.M. shift than it is the night shift?

M. Kreitz: Once again I don't know why these policies are. They seem to be fairly prevalent. I think that probably it is because many of the night personnel we get are nurses who are married, perhaps have children, and can work at night and get some sleep in the evening while their husbands are home to look after and to care for the children.

Teaching Aids

A. Clarke: To come back to this conference, I notice this year that there has been an increased number of exhibitors who have come to your convention. We have all heard about never underestimating the power of the O.R. nurse as a purchasing influence, and I wonder if that might be the reason why exhibitors are so interested in your group. I was particularly conscious of the educational approach of these exhibitors and how much interest the individual O.R. nurse demonstrated in stopping at each one of these booths and getting as much information as possible. Have you really been helped by these exhibits?

D. Walk: Yes, I think the exhibitors have done a great deal for the education of the operating room nurse both at the convention and through their salesmen's visits to the operating rooms. I have told my staff, over and over again, to pay close attention to what the exhibitor or the salesmen have to say to us because we do learn from them, and we have no other way, actually, of learning about the new equipment on the market.

The exhibitors have told me many times throughout this convention that they have been very pleased with it, above and beyond many of the ones they have attended. The exhibitors feel that in many instances they cannot get into the hospitals to see the operating room nurse who is actually the person who uses their equipment. The administrators stop them or someone at the front office stops them, saying that they will take up too much time. These companies feel very strongly about the care of their equipment, and they want to see that it is used properly. So if they can't come in to show us how to use the equipment and how to take care of it, the equipment suffers. Therefore, they feel that conventions, such as these, are beneficial to us all.

A. Clarke: Do you think meeting together in local units has given you more of a sense of security in your own decisions? And has it helped you to learn more about techniques that you may not have been able to learn about by reading professional literature, for instance?

M. Kreitz: That is very true. One of our problems, and I suppose that is true in other areas, is that the staff surgeons in hospitals in our area seem to feel the techniques put into effect should be the ones that are in

accepted use in our area. I think that is one of the biggest advantages of our local meetings. It certainly gives us a talking point if we have gotten together with other nurses in the area and they, too, agree.

Merit of AORN Groups

D. Walk: We feel that these organizations have been worthwhile, especially they have helped the small private hospital with only one or two operating room nurses. These hospitals are not detailed as much as larger institutions. They are not up on the latest techniques because they do not have all the research centers. They do not have many of the advantages of larger hospitals. It is the nurses in these hospitals who are helped the most.

A. Clarke: Do you think the O.R. problems, which seem to be perennial, are anywhere near the point where nurses can find answers and standardized procedures?

D. Walk: In some fields, yes, but in many fields, no. Because of the amount of research that is being done daily, things are changing. Surgery itself is expanding, so there is a need all the time to grow along with it. There are fields opening up which none of us know very much about, even as far as assisting the surgeon, because the field is also new to the surgeon. Therefore, at this point we don't know yet whether it will ever be possible to set up a standard manual that can be used year after year.

A. Clarke: Do you find that the surgeon depends upon the O.R. supervisor to keep up to date with his data?

D. Walk: I think he depends on the operating supervisor in many instances. In my own situation surgeons come to me asking questions about the new instruments, thinking that I have seen the detail man. Also, I post all the brochures and notices that come in on new equipment and techniques on a bulletin board. If they think the item is worthwhile, they come to me for ordering. Naturally, in our hospital, most of the new techniques and new solutions on the market are the concern of the operating room supervisor.

M. Kreitz: I find that to be pretty much my case.

A. Clarke: In the army it's so standardized you do not have to worry?

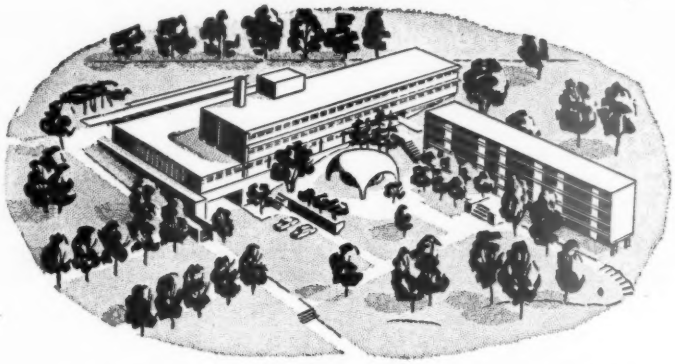
M. Whitton: Not a bit.

A. Clarke: Then it would seem to me that the best operating room supervisor is the one with the most experience. Is that correct?

D. Walk: It is my belief that an operating room supervisor has to have a great deal of experience that she has developed coming up through the ranks. I think experience is very important. A degree of course rounds out her personality, helps her personal growth and development, but experience is what the operating room supervisor must have.

A. Clarke: In summary, then, you say that the degree is fine, and the more experience that goes along with that degree makes a well-rounded operating room supervisor, but one without the other does not give the product that we are looking for.

All: We are in agreement.



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CLEVELAND OHIO JOB OPPORTUNITIES FOR REGISTERED NURSES: For 398 bed non-sectarian general hospital with School of Nursing. Full or part-time. Excellent opportunity for study at nearby Western Reserve University. Starting salary $240-$260 based on experience plus $1.00 per diem for evening or night duty. Operating room nurses $10 per mo. additional. 2 weeks vacation, 6 holidays, 10 days sick leave. We will assist you in finding living accommodations. For detailed personnel policies write Director of Nursing, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

CLINICAL INSTRUCTORS: For Obstetric, Pediatric and Medical Nursing. For further information write to Director, Mercy School of Nursing, Hamilton, Ohio.

GENERAL DUTY: Small private hospital, 2 weeks vacation, 6 holidays, 12 days sick leave per year, maintenance if desired, pleasant working conditions, salary open. Superintendent of Nurses, Sanford Hospital, Perryton, Tex.

GENERAL DUTY: 40 hr wk, 84 bed hospital, finest equipment, very liberal personnel policies and pleasant working environment. Must be willing to rotate shifts. Salary range $277 to $360 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY, HEAD NURSES & NURSE SUPERVISORS: For work in a mental hospital. Psychiatric experience necessary for all but general duty nurses. Salary starts at $3312 for general duty, $3628 for head nurses, $4147 for nurse supervisors. Must be registered in the state. Apply Personnel Office, Central State Hospital, Box 271, Petersburg, Va.

GENERAL DUTY NURSES: 75 bed general hospital. Prevailing wages paid, differential for evening and night shifts. For further details please write Administrator, Cedar Valley Hospital, Charles City, Iowa.

GENERAL DUTY NURSES: Needed for a 2300 bed Veterans Administration Hospital located in suburban area only 11 miles from downtown Chicago. Basic starting salary $3740 per year with yearly increase to $4540; higher salaries based upon experience and educational qualifications. 30 day annual leave. 15 days sick leave, 8 holidays per year. 40 hr. wk. Age limit for entrance, under 40 years. Current registration as a graduate nurse in a State or Territory of the United States or in the District of Columbia. Complete maintenance available at minimal cost, direct transportation to the City. Write Chief, Nursing Service, Veterans Administration Hospital, Hines, Ill.

GENERAL DUTY NURSES: Needed for staff position in crippled children's orthopedic hospital. Salary $245 per mo. plus complete maintenance or $319.50 without maintenance, 15 days vacation, 15 days sick leave, 5 day work week. Contact Director of Nurses, Carrie Tingley Hospital for Crippled Children, Truth or Consequences, N.M.

GENERAL DUTY NURSES: Attractive working conditions in America's most interesting city. 500 bed hospital, 41½ hour week. Write Personnel Director for salary scale, personnel

policies. Southern Baptist Hospital, 2700 Napoleon Ave., New Orleans, La.

GENERAL DUTY NURSES: 5 day week, 3 week vacation, 7 paid holidays, paid overtime, liberal sick leave and hospitalization benefits, attractive living quarters, modern well-equipped 210 bed hospital. Salary starts at $230 a month. Rotating shifts. Pleasant New York City suburb, 35 minutes from Grand Central Station. Contact Director of Nursing Service, White Plains Hospital, White Plains, N.Y.

GENERAL DUTY NURSES: For 76 bed general hospital in university town. Prevailing salaries paid. Full maintenance available. Redlands Community Hospital, Redlands, Calif.

GENERAL DUTY NURSES: 100 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies, 40 hr. wk. Starting salary $237.50 with a charge of $22.50 for full maintenance. Additional $10 per mo. for evening and night duty with regular increases. Surgical nurses starting salary $247.50 plus $5 per call after 5 p.m. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES: For 50 bed general hospital located in southern Colorado. Favorable climate, year around sports, college town. 40 hr. wk., vacation, sick leave, holidays, increases given. Contact Superintendent, Community Hospital, Alamosa, Colo.

GENERAL DUTY STAFF NURSES: New and modernized 300 bed general hospital offers top salaries and opportunities to advance. Evenings $76.80-$89.60 per week; nights $73.60-$86.10; days $64.00-$75.60. Openings in Medical, Surgical, Obstetrics, Pediatrics, Operating Room and Emergency Room. 40 hr. wk., merit increases, liberal policies. On Long Island Sound, 45 mins. to N.Y.C. Modern nurses residence and school. Apply to Director of Nursing, Stamford Hospital, Stamford, Conn.

GENERAL STAFF NURSES: This is a nice place to work in preferred department of 200 bed general hospital with liberal personnel policies including 40 hr. wk., choice of two schedules, retirement plan, paid hospitalization insurance premium, cumulative 30 day sick leave, pro-rated and progressive vacation, 6 holidays annually, meals at cost, rooms for $20 monthly in residence beautifully located directly on Detroit River and 30 minutes from Detroit. Beginning salary, evenings $304.47-$313.13; nights, $299.47-$308.13; days, $289.47-$298.13. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care. $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GERIATRIC STAFF NURSES: For small hospital unit in Home for Aged. Good salary plus full maintenance, Chicago suburb. Write Mrs. Naoma Grosboll, R.N., Box 231, Hinsdale, Ill.

HEAD NURSE-MEDICAL & SURGICAL: 332 bed general hospital with School of Nursing, degree and experience desired. 40 hr wk., liberal personnel policies, living accommodations available, salary commensurate with qualifications, position available immediately. Apply Director of Nursing, Toledo Hospital, Toledo, Ohio

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer or allied diseases. Good basic preparation required; learn specialty here. Staff nurses $260-$300 plus evening bonus $50 mo., night bonus $40 mo. Uniforms laundered, paid Blue Cross, Social Security, 4 weeks vacation annually. Inservice ed, Columbia University Learn-Earn Program available. Housing agent helps you locate. Write or 'phone Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 East 68th St., N.Y. 21, N.Y.

INSTRUCTOR: Medical or Surgical Nursing Arts. Classroom teaching and Floor Supervision. Degree required, experience preferred. Apply Dean, Knapp College of Nursing, Santa Barbara, Calif.

INSTRUCTOR, PHYCHIATRY: Opportunity to enter a highly challenging field of student instruction. B.S. Degree desirable. College-level work beyond basic training acceptable. Psychiatric experience essential (6 mos. to 1 yr.). Salary based on qualifications. Low cost maintenance available. Contact Director of Nursing, Cleveland City Hospital, 3395 Scranton Road, Cleveland 9, Ohio.

MALE NURSE: Interested in field of urology or male attendant trained in urology to work with one urologist in hospital and office work. Salary open. Southwest. Write Director of Administration, Lovelace Clinic, 4800 Gibson Blvd. SE, Albuquerque, N.M.

MEDICAL & SURGICAL CLINICAL INSTRUCTOR: For lovely 275 bed hospital school. Midwestern state. Degree required. Liberal 5 day week, Social Security, 3 wks. vacation, 6 holidays, 14 days sick leave. Write Box LMH-1 c/o R.N. Magazine, Oradell, N.J.

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NURSE: Tonawandah Riding Camp for Girls, New Londin, N.H. Dartmouth-Lake Sunapee resort region. Enrollment 50. $300 & mtce. for July and August. Write Mrs. Elmer Bussell, 245 Clifton St., Malden, Mass.

NURSE: Male or female, for industrial clinic and infirmary in Glassboro, N.J. Write giving references and experience. Box No. CSG-1 c/o R.N. Magazine, Oradell, N.J.

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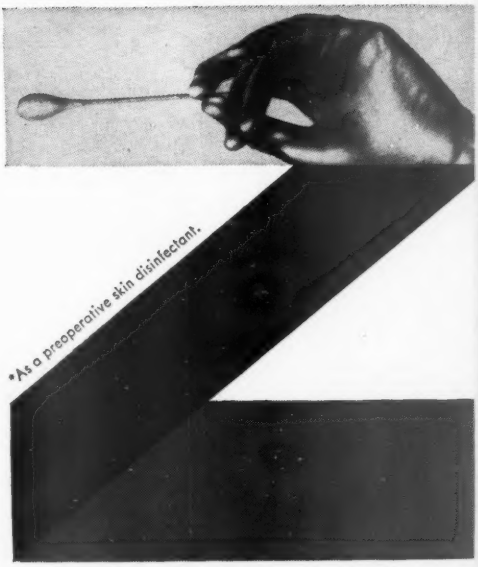

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NURSE ANESTHETIST: Wanted for oral surgeon's office. Experience necessary. Salary $300 to start. 40 hr. wk. Pleasant working conditions. Apply to Mrs. Howell T. Hunt, Anesthetist, 1032 Maison Blanche Bldg., New Orleans, La.

NURSE ANESTHETIST: Approved hospital near Detroit. $475 per mo. Overtime after 40 hrs. per week. Living quarters available. Wyandotte General Hospital, Wyandotte, Mich.

NURSE ANESTHETISTS: Three, to increase staff. Approved AANA Training School. Good working conditions. Medical Anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pa.

NURSE SUPERVISORS: For both 3 to 11 and 11 to 7 shifts. Must be registered nurse with some supervisory experience and able to carry responsibility for 150 bed hospital on shift to which assigned. 40 hr. wk., vacation and sick leave granted. Salary open. Apply Administrator, Robinson Memorial Hospital, Ravenna, Ohio

NURSES: General Duty Nurses wanted for summer positions, also permanent Night Supervisor for OBS. Spend your summer in cool Bar Harbor gateway to beautiful Acadia National Park. Write for full details. Mt. Desert Island Hospital, Bar Harbor, Me.

NURSES: General Duty, Operating Room and Assistant Director of Nurses for 150 bed hospital. Apply to Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

NURSES: Psychiatric registered nurses, head nurses, supervising nurses, psychiatric nursing instructors (men and women) for State Hospital. Immediate assignment for areas where student affiliate nurses will be assigned. Salaries ranging from $3360 to $5040, opportunities for advancement, excellent retirement and insurance plan, 40 hr. work week, full maintenance only $38 per mo. Working conditions meet approved minimum employment standards of Illinois State Nurses' Association. Write Dr. R. C. Steck, Superintendent, Anna State Hospital, Anna, Ill.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES—GENERAL DUTY & SURGICAL: For 250 bed hospital in residential suburb of Chicago. 40 hr. wk. Cash salary $230 for night duty, $225 evening duty and $215 day

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duty. $10 increase after 60 days and at regular intervals. $15 differential for surgical nurses. Full maintenance in addition to salary includes single room in new nurses residence plus meals and laundry. Low rental apartments for married nurses. 2 to 4 weeks vacation, 6 holidays. Sick time policy. Free life insurance. Blue Cross hospitalization. Leave of absence with full salary for post graduate study granted to qualified nurses. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

NURSING ARTS INSTRUCTOR: Beginning August. Degree required. Salary dependent upon preparation and experience. Admit one class a year, 82 students in the school. Excellent personnel policies, including 40 hr. wk., all cash salary, Social Security and retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton, N.J.

NURSING ARTS INSTRUCTOR & SCIENCE INSTRUCTOR: In approved School of Nursing in 190 bed General Hospital. One class of 25 students admitted yearly, new Nurses Residence with modern teaching facilities. Preperation with degree and teaching experience preferred. Salary open. Liberal personnel policies. Apply Director of Nursing, Bethesda Hospital, Zanesville, Ohio

NURSING OPPORTUNITIES: Excellent pay and working conditions. Openings for registered medical-surgical, obstetrical and operating room nurses for day, evening and night duty. Research Hospital, located in the Heart of Kansas City, Mo., offers you unlimited opportunities for professional growth through on-the-job educational programs and will cooperate with those interested in further education at any of the institutions of higher learning in Greater Kansas City. Minimum starting wage $250 per mo., $20 per mo. differential for eve. and night duty. Work 40 hr wk, receive paid vacation each yr, plus 6 legal holidays and sick leave. Laundry of uniforms. Promotions from within staff for qualified employees. Temporary housing provided at $30 per mo for out-of-town residents. Large modern hosp. with excellent medical and nursing staff and with the best equipment and good working conditions. Apply today—don't wait. Write, call or apply in person to the Director, Department of Nursing, Research Hospital, 2300 Holmes St., Kansas City, Mo. 'Phone Harrison 4105.

NURSING SPECIALTIES: Nursing opportunities in a specialized field are being offered to nurses who can fill Chief, Assistant Chief and Staff Nurse positions in American Red Cross blood centers. Minimum requirements for Chief and Assistant Chief Nurses are a college degree, or at least 2 years of college work, plus experience in teaching, administration and public relations. For Staff Nurses, at least one year of general experience is required. Inquiries should be directed to Mr. Norman A. Durfee, Director for Personnel Services, National Headquarters, American National Red Cross, Washington, D.C., and reference should be made to the Blood Program.

OBSTETRICAL SUPERVISOR: Capable taking complete charge department covering three floors of modern, air-conditioned building. Salary depends on ability, experience, advanced training. Liberal employee benefits. Apply Personnel Director, Southern Baptist Hospital, New Orleans, La.

OPERATING ROOM NURSES: Immediate appointments. 511 bed newly enlarged and finely equipped hospital. 10 operating rooms now completed. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living cost reasonable. Within pleasant driving distance advantages of metropolitan Cleveland, Columbus and Pittsburgh Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

OPERATING ROOM NURSES: 300 bed hospital, 40 hr. wk., all cash salary. Special consideration for experience and advanced preparation. Bonus for "on call". Liberal personnel policies, including Social Security, plus a retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton 8, N.J.

OPERATING ROOM NURSES: 125 bed approved general hospital. 40 hr. wk. Paid vacations and sick leave. Maintenance available. Contact Director of Nurses, Jamestown General Hospital, Jamestown, N.Y.

OPERATING ROOM NURSES: At Medical Center. Start $270, increases at 6 mos, 1 yr. and 2 yrs, overtime premium pay, paid vacation, 6 paid holidays, sick leave, Social Security, we pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

OVERSEAS JOBS: Interested in overseas nursing? Many companies need nurses in their dispensaries and company-owned hospitals. Send $1 for list which includes a large number of companies operating in foreign countries. Satisfaction guaranteed. Len Rathe, Box 26244, Los Angeles 26, Calif.

PEDIATRICS-HEAD NURSE RN: BS Degree or credits, experienced. Uniform laundry. 4 weeks vacation, 11 holidays, sick leave, paid hospitalization, maintenance available. Montefiore Hospital, 210 St. & Bainbridge Ave., Bronx, N.Y.

PROFESSIONAL NURSES: For Operating Rooms, Emergency Room, Out-Patient Department, Medical-Surgical, Pediatrics, Psychiatry, Orthopedics, Urology. Salary and personnel policies comparable to other hospitals in area. Teaching Hospital 6 blocks from Teachers College, Columbia University. Write Director of Nursing, Box K, St. Luke's Hospital, 421 West 113th St., New York 25, N.Y.

PSYCHIATRIC NURSES: Openings in State Mental Hospitals for Educational Director (Psychiatric Nurse II), beginning salary $415 per mo. and supervisory positions (Psychiatric Nurse I), beginning salary $358 per mo. Good personnel policies. Apply to Personnel Office, Larned State Hospital, Larned, Kans.

[Turn the page]

PUBLIC HEALTH NURSES: Vacancies in New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $3080. 37 hr. wk., liberal vacation and sick time allowances, pension rights, in-service training. Applicants (except New York State Veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York 13, N.Y.

PUBLIC HEALTH NURSING STAFF POSITIONS: Official Agency, northern California, rural. Applicant should be eligible for registration and have a Public Health Nursing Certificate in the State of California, as well as having completed a university program of study in public health nursing. It is desirable for applicant to have had at least one or two years experience. Beginning salary for well-qualified nurse $332 per mo. Write John A. Carswell, M.D., Humboldt-Del Norte County Health Department, Eureka, Calif.

QUALIFIED SUTURE NURSES: $275-$315. Opportunity for experience in advanced procedures, assisting leading surgeons in teaching center. Work with top operating room nurses, all modern facilities. 5 day weekly schedule, minimum on-call. 4 weeks vacation, Social Security, paid Blue Cross, other benefits. University-affiliated inservice education plus access all NYC universities. Good basic preparation required; learn specialty here. Housing agent helps you locate. Write or 'phone Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 East 68th St., New York 21, N.Y.

R.N.: Assistant supervisor of nurses in 260 bed Chronic Disease Sanitarium. Salary open. Apply J. O. Smigel, M.D., Medical Director, Pinehaven Nursing Home, Pinewald, N.J.

R.N.'s (8): Permanent positions. $220 per mo., plus maintenance if living in. 5 day week, usual holidays and vacations. Additional positions also available for summer. Apply J. O. Smigel, M.D., Medical Director, Pinehaven Nursing Home, Pinewald, N.J.

R.N.'s: 150 bed general hospital with plans in process for new 75 bed addition in fabulous Las Vegas. Starting salary $250 with $15 increase after 3 months, annual increments, vacation and sick time. For further information write Southern Nevada Memorial Hospital, Las Vegas, Nev.

R.N.'S: New 57 bed general hospital. 5 day week with room and board. Write to Mary K. Moloney, R.N., Director of Nurses, Liberty Maimonides Hospital, Liberty, N.Y.

R.N.'S: Under age 50. Beginning salary $310 per month, $5 longevity increase every 6 mos. for 3 yrs. Retirement plan, sick leave benefits, 11 holidays, 3 weeks vacation, 40 hr. wk. New modern residence. State eligibility for California registration and submit photo to Director of Nurses, Tulare-Kings Counties Tuberculosis Hospital, Springville, Calif.

R.N. SUPERVISOR: For small nursing home in Mount Vernon, N.Y. 25 mi. from New York City. 8 hr. duty, 5 day week, excellent salary.

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REGISTERED NURSES: Immediately for small infirmary, orphanage. Salary $250 plus complete maintenance, paid hospitalization, 7 holidays, sick leave, annual vacations. Contact Edgewood Infirmary, 1801 Vicente St., San Francisco, Calif.

REGISTERED NURSES: In progressive 250 bed fully approved hospital located in beautiful, exciting western city with ideal climate, mild winters. 5 day week, 40 hrs., starting salary $265 with automatic increase every 6 mos., of $100 per year, or $8.33 per mo. up to three years. $10 per mo. differential paid to those working afternoon and night shifts. Minimum wage scale for surgery nurses is $275. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

REGISTERED NURSES: For obstetrical or general floor duty in fully approved 150 bed Chicago Hospital for 7-3, 3-11 or 11-7 shifts. Room, Board and Laundry and $260 per mo. Steady employment, excellent working conditions and opportunity for advancement. Give full information in first letter. Box AHC-1 c/o R.N. Magazine, Oradell, N.J.

REGISTERED NURSES: Salary scale $240 to $275 per mo, 40 hr. wk, differential for night duty, $17 per mo; beginning salary based on length and recency of experience, increases every 6 mos, increases beyond the maximum on basis of merit, 2 weeks illness allowance, 3 weeks vacation, opportunity for university study. New Modern Division of Hospital, capacity 250 patients, opening this Fall, located in pleasant residential section. Address inquiries to: Director of Nursing, The Rochester General Hospital, Rochester 8, N.Y.

REGISTERED NURSES: For expanding services to 215 beds. Functionally modern hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter resort areas. Staff and charge positions open. Starting salaries are dependent upon educational background and experience with a minimum of $260 to $300 per month. Monthly differential of $20 for afternoon duty and $15 for night duty. 40 hr. wk. Excellent personnel policies. Stimulating and progressive environment. Nursing department has collegiate education affiliation. Accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

REGISTERED NURSES: Basic salary $308.65 per mo (includes cost of living adjustment). Yearly raises. Premium for afternoon and night duty. 8 hr. day, 5 day week, 2 consecutive days off. Paid vacations. 7 holidays per year. Accumulative sick time based on length of service. Nurses' Home. Single rooms $15 per mo. and double rooms $10. Cafeteria meals at nominal cost. 4 uniforms laundered weekly without charge. Employees covered under provisions Railroad Retirement

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REGISTERED NURSES: For new 39 bed, northern Wyoming hospital, to rotate shifts. Excellent salary and personnel policies. Contact Superintendent, Campbell County Memorial Hospital, Gillette, Wyo.

REGISTERED NURSES: For general duty and supervisors in modern 58 bed hospital located in beautiful resort area on the shores of Lake Michigan. Excellent salaries with liberal personnel policies. $15 differential for 3-11 and 11-7 shifts. Apply Director of Nurses, The Grand Haven Municipal Hospital, Grand Haven, Mich.

REGISTERED PROFESSIONAL NURSES: For supervisory, educational and general staff positions. Liberal personnel policies. 40 hr. week. Differential salary for evening, nights and operating room. Social Security. Christ Hospital, 176 Palisade Ave., Jersey City, N.J.

REGISTERED STAFF NURSES: Immediate appointments. 511 bed newly enlarged and finely equipped general hospiital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics or contagion units. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living costs reasonable. Within pleasant driving distance advantages of metropolitan Cleveland, Columbus and Pittsburgh. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

SCHOOL OF ANESTHESIA: Approved by the American Association of Nurse Anesthetists. Open to registered nurses of accredited schools of nursing. For complete information and application blanks write to Everard R. Hicks, Director of the School of Anesthesia, The McLeod Infirmary, Florence, S.C.

SCIENCE INSTRUCTOR: Nationally accredited school of nursing. One class of approximately 40 students admitted yearly. B.S. Degree minimum. Salary dependent on education and experience. 40 hr wk, 8 holidays with full pay, 4 weeks vacation yearly, liberal sick leave. 500 bed voluntary hospital. 10 mi. from New York City with direct transportation to Times Square in 35 minutes. Universities and Colleges available both in New Jersey and New York for further education. Write to: Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 8, N.J.

STAFF NURSES: For 850 bed hospital, affiliated with Western Reserve University Medical School. Opportunities available for varied Medical and Surgical clinical experience, be-

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STAFF NURSES: For 225 bed Southern California general hospital. 40 hr. wk., salary range $245-$275. Paid vacation, sick leave. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

STAFF NURSES: Wide clinical experience, 40 hour week, starting salary of $280 a month. Please write to Department of Nursing for further details, University Hospital, Ann Arbor, Mich.

STAFF NURSES: All services. 135 bed general hospital. No school. Organized medical staff. Apply to the Director of Nursing, Archbold Memorial Hospital, Thomasville, Ga.

STAFF NURSES: For 466 bed Tuberculosis Hospital about 20 miles from New York City. Beginning salary $271 monthly, increments $10 a month yearly to $321, $10 increase for evening or night duty. 40 hr. 5 day work week with overtime pay for any work over 40 hours. Liberal vacation, holidays and sick time. Full maintenance available at $52 a month. Pension Plan or Social Security available, depending upon age, physical condition and other determining factors. Apply Supt. of Nurses, Essex County Sanatorium, Verona, N.J.

STAFF NURSES: For 45 bed general hospital, completely remodeled and new equipment. 44 hr. week. Starting salary $250 up. Good working conditions. Liberal personnel policy. Apply Administrator, Coon Memorial Hospital, Dalhart, Tex.

STAFF & OPERATING ROOM NURSES: New 104 bed general hospital. Latest equipment, ideal location banks of St. Joseph River, heart of fruitbelt, Lake Michigan shores. Living accommodations available. Jr. College in area. 2 hrs from Chicago. 40 hr. week, basic salary $234, shift bonus, good personnel policies, friendly community. Details write Nursing Director, Memorial Hospital, St. Joseph, Mich.

STAFF NURSES: For 72 bed new hospital, all modern equipment. 44 hr. wk., good working conditions, liberal personnel policies. Apply Director of Nursing, Kerbs Memorial Hospital, St. Albans, Vt.

STAFF NURSES: For small hospital in Mountain Area. Good policies. Year around resort town. Marriages deplete our staff. St. John's Hospital, Jackson, Wyo.

STAFF NURSES-OPERATING ROOM NURSES: For modern 650 bed tuberculosis hospital affiliated with Western Reserve University and approved by joint commission on accreditation of hospitals. 40 hr. week, 5 days. Salary $293 to $323 with automatic increases. Full maintenance available at minimum rate. Housing for two or more nurses. Advancement for eligible applicants. Meets approved minimum employment standards of the State Nurses' Association. Apply to Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio

SUPERVISOR: Communicable diseases (acute and convalescent polio included). 11 PM to 7 AM. Specialized training in communicable disease not required. Experience in both Staff and Head Nursing required. An opportunity to learn supervision of newly organized respirator center. 40 hr. wk. Sunday through Thursday. Salary open based on qualifications. Low cost maintenance available. Contact Director of Nursing, Cleveland City Hospital, 3395 Scranton Road, Cleveland 9, Ohio.

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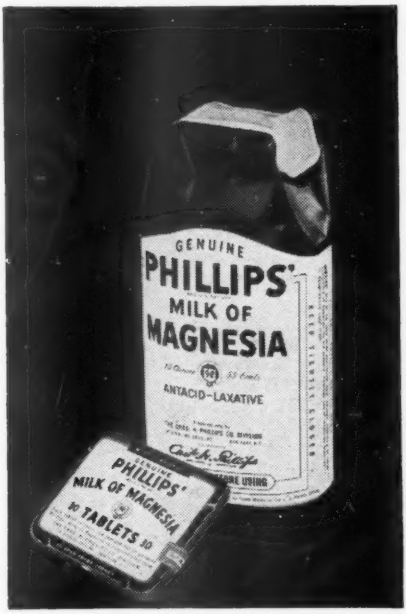

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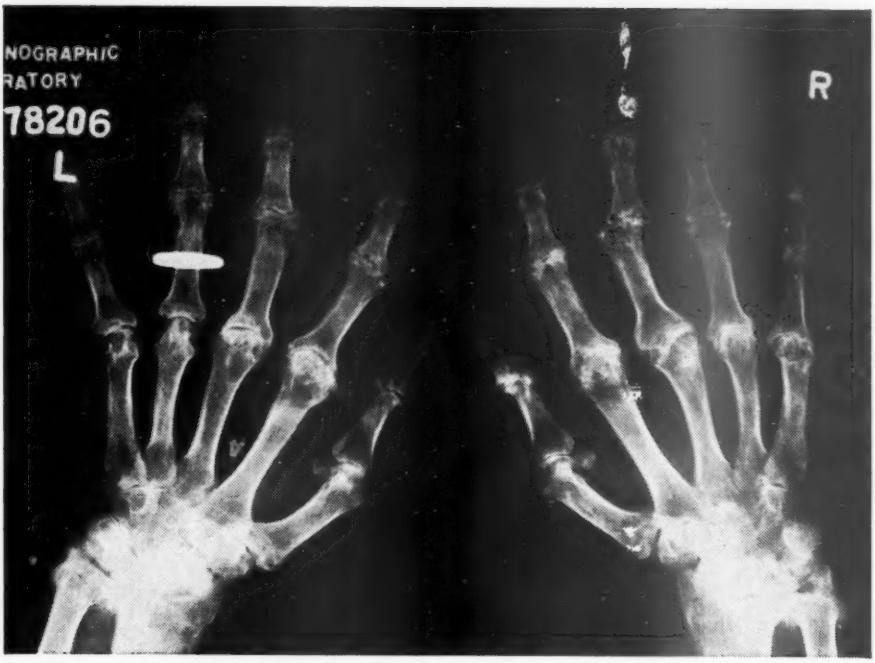

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References: 1. Fremont-Smith, P.: In press. 2. J.A.M.A. 141: 124, 1949. 3. M. Times 81: 41, 1953.

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